HealthSelect of Texas®

Master Benefit Plan Document

Employees Retirement System of Texas
HealthSelect[SM] of Texas (Out-of-State) Plan

Effective: September 1, 2024
Group Number: 238000

BlueCross BlueShield of Texas

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SECTION 1 - WELCOME

Important Information Box

- Member services, claim inquiries, Recommended Clinical Review (RCR), Personal Health Support: (800) 252-8039 (TTY: 711);
- Claims submittal address: Blue Cross and Blue Shield of Texas - Claims, P.O. Box 660044; Dallas, Texas 75266-0044; and
- Online assistance: **healthselectoftexas.com**.

HealthSelect of Texas® (HealthSelect) is a self-funded benefit plan offered through the Texas Employees Group Benefits Program (GBP or Program) by the Employees Retirement System of Texas (ERS).

HealthSelect is pleased to provide you with this Master Benefit Plan Document (MBPD), which describes the health Benefits available to you and your eligible covered family members. It includes information regarding:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This MBPD is designed to meet your information needs. It supersedes any previous printed or electronic MBPD for this Plan.

Important
Health care services, supplies or Medications and Injections are only Covered Health Services if Medically Necessary (See definitions of Medically Necessary and Covered Health Service in Section 13, *Glossary*). The fact that a Physician or Other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms, does not make the procedure or treatment a Covered Health Service under the Plan.

ERS intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice, or as directed by the state of Texas. This MBPD is not to be construed as creating an employment contract or any rights or benefits, except as expressly provided herein as authorized and limited by Chapter 1551 of the Texas Insurance Code.

Blue Cross and Blue Shield of Texas (BCBSTX) is a health care Claims Administrator and the third-party administrator for HealthSelect. One of BCBSTX' goals is to give you the tools you need to make wise health care decisions. BCBSTX also administers HealthSelect claims. Although BCBSTX will assist you in many ways, it does not guarantee any Benefits. The GBP, as administered by ERS, is ultimately responsible for paying Benefits described in this MBPD.

Please read this MBPD thoroughly to learn how the HealthSelect Out-of-State Plan works. If you have questions, contact your Benefits Coordinator or a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711).

How To Use This MBPD

- Read the entire MBPD and share it with your family. Then keep it for future reference.
- Many of the sections of this MBPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your MBPD and any future Amendments at **healthselectoftexas.com** or you may request printed copies by contacting BCBSTX at (800) 252-8039 (TTY: 711).
- Capitalized words in the MBPD have special meanings and are defined in Section 13, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Participants as defined in Section 13, *Glossary*.
- The Employees Retirement System of Texas is also referred to as the Plan Administrator.
- If there is a conflict between this MBPD, MBPD Amendments and any benefit summaries provided to you, this MBPD and its Amendments will control.

Important
Your Provider does not have a copy of your MBPD and is not responsible for knowing or communicating your Benefits.

Nondiscrimination and Accessibility Requirements

BCBSTX, on behalf of itself and its affiliated companies, and ERS comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Neither BCBSTX nor ERS excludes people or treats them differently because of race, color, national origin, age, disability, or sex.

BCBSTX and ERS provide free aids and services to people with disabilities to communicate with them effectively, such as:

- qualified sign language interpreters;
- written information in other formats (large print, audio, accessible electronic formats, other formats);
- free language services to people whose primary language is not English, such as: qualified interpreters; and
- information written in other languages.

If you need these services, please call BCBSTX at (800) 252-8039 (TTY: 711), or you may call ERS.

If you believe that BCBSTX has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in writing by mail or email with the Civil Rights Coordinator identified below. A grievance must be sent within 60 calendar days of the date that you become aware of the discriminatory action and contain the name and address of the person filing it along with the problem and the requested remedy.

A written decision will be sent to you within 30 calendar days. If you disagree with the decision, you may file an appeal within 15 calendar days of receiving the decision

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Blue Cross and Blue Shield of Texas Civil Rights Coordinator
Office of Civil Rights Coordinator Attn: Office of Civil Rights Coordinator 300 E. Randolph St., 35th Floor Chicago, Illinois 60601 (855) 664-7270, (voicemail) **CivilRightsCoordinator@bcbsil.com**

If you need help filing a grievance, the Civil Rights Coordinator identified above is available to help you.

You can also file a complaint directly with the U.S. Dept. of Health and Human services online, by mail or email:

Online:

ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Mail:
Centralized Case Management Operations
U.S. Dept. of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Email:
OCRComplaint@hhs.gov

For more details on how to file a complaint, please visit **hhs.gov/civil-rights/filing-a-complaint/index.html** for details.

Getting Help in Other Languages or Formats

You have the right to get help and information in your language at no cost. To request an interpreter, call BCBSTX at (855) 710-6984, press 0. (TTY: 711).

This notice is also available in other formats such as large print. To request the document in another format, please call BCBSTX at (800) 252-8039, (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

Language	Translated Taglines
1. Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
2. Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
3. Chinese	注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：1-711）或咨询您的服务提供商。
4. Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
5. Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.
6. Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔(TTY: 711) 1-855-710-6984 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
7. Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
8. French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY :711) ou parlez à votre fournisseur.
9. Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Language	Translated Taglines (Cont'd)
10. Persian-Farsi	توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 1-855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
11. German	ACHTUNG: Wann du Pennsylvanisch Deitsch schwetzscht, sin Hilfsdienst fer die Sprooch fer dich gratis verfügbar. Passende Hilfsmittel un Dienscht, fer Informatione in zugängliche Formate ze gebbe, sin aa gratis verfügbar. Ruf 855-710-6984 (TTY: 711) oder schwetz mit dein Anbieter.
12. Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
13. Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
14. Japanese	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。855-710-6984（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。
15. Laotian	ຊືນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 855-710-6984 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.
16. Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.

SECTION 2 - INTRODUCTION

What This Section Includes

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for selecting coverage for yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility for the Texas Employees Group Benefits Program

You are eligible to enroll in health coverage offered by the Texas Employees Group Benefits Program (GBP or Program) if you are a regular full-time or part-time State Agency Employee as defined in Section 13, *Glossary*, an Institution of Higher Education Employee as defined in Section 13, *Glossary*, or a Retiree as defined in Section 13, *Glossary*, with at least 10 years of service credit at the time of retirement, or required or permitted to enroll by Chapter 1551 of the Texas Insurance Code.

Eligibility for the Out-of-State Plan

As an **Employee**, you are eligible for coverage in the Out-of-State Plan if neither the county of your personal residence nor your place of employment is in the Plan Service Area.

- You must notify your Benefits Coordinator directly or go to ERS OnLine at **ers.texas.gov** to notify your Benefits Coordinator, that you base your eligibility for coverage on either the county of your personal residence or your place of employment. If both the location of your residence and place of employment are outside the Plan Service Area, your coverage will be the Out-of-State Plan. If the location of your residence changes from outside the Plan Service Area to inside the Plan Service Area, your coverage may change from the Out-of-State Plan to the In-Area Plan. Changes will become effective the first day of the month following your change of personal residence.
- If you base your eligibility for the In-Area Plan on the county of your place of employment, then a change in location of residence will not cause a change in plan.
- If you are age 65 or older and Actively Working, you are eligible for coverage in the In-Area Plan, with Medicare as your Secondary Plan.

As a **Retiree**, you may be eligible for coverage in the Out-of-State Plan depending on which Plan you had before retirement, the county of your personal residence and your age.

If you retire while under age 65 and you are not Medicare eligible:

- If your personal residence or county of eligibility is located outside the Plan Service Area, you are eligible for coverage in the Out-of-State Plan.

- If, prior to retirement, you lived outside of the Plan Service Area but elected coverage in the In-Area Plan based on the county of your place of employment, you may elect to be covered in the In-Area Plan upon retirement. You may continue coverage in the In-Area Plan until you either reach age 65 or change to the HealthSelect Out-of-State Plan based on a change in residence outside of the Plan Service Area. Once you change to the HealthSelect Out-of-State Plan, you may not change back to the In-Area Plan unless you, while under age 65, move your residence inside the Plan Service Area.

If you retire while under age 65 and you are Medicare eligible:

- If your personal residence is located in the Plan Service Area, you are eligible under the In-Area Plan. However, Medicare is your Primary Plan and HealthSelect coverage is your Secondary Plan. See Section 9, *Coordination of Benefits (COB)*, for more information.

If you retire at age 65 or later, you are not eligible for the In-Area Plan but may be eligible for the HealthSelect Secondary Plan.

Important Reminder
If you retired after September 1, 1992, or if you are a Dependent of a Subscriber who retired after September 1, 1992, and you are eligible for Medicare, you will need to enroll in Medicare.
If you do not enroll in Medicare, Benefits payable under the Plan will be reduced, and that cost could be significant. For more information on how and when to enroll, contact Medicare at (800) 633-4227, or visit **Medicare.gov**.

If you are eligible for Medicare due to End Stage Renal Disease, you should enroll in Medicare. If you choose not to enroll, Benefits payable under the Plan will be reduced, and that amount could be significant.

For more information on how Benefits will be calculated if you are eligible for Medicare and choose not to enroll, see Section 9, *Coordination of Benefits (COB)* under the heading *Determining the Allowable Amount When This Plan Is Secondary to Medicare.*

Your eligible **Dependents** may also participate in the Program and the Out-of-State Plan. An eligible Dependent is considered to be:

- Subscriber's spouse – an individual to whom the Subscriber is legally married. This includes a ceremonially married spouse whose marriage is documented by a valid marriage license or an informally married spouse whose marriage is documented by a valid Declaration of Informal Marriage filed with the appropriate governmental authority;
- Subscriber's child who is under age 26, including a natural child, a stepchild, a foster child, a legally adopted child, and a child placed for adoption or ward, as defined in Section 1002.030, Texas Estates Code;
- a child who is not a Subscriber's child referenced in the immediately preceding bullet point and who is related to the Subscriber by blood or marriage and was claimed as the Subscriber's dependent on his/her federal income tax return for the year prior to enrolling the child and for each subsequent year in which the child is enrolled (unless the child is born in the year first enrolled, or the Subscriber has shown good cause for not claiming the child); or
- a child age 26 or over who (i) is certified by an approved practitioner to be mentally or physically incapacitated from gainful employment and (ii) either earns less than the monthly wage standard for enrolling in Children's Health Insurance Program in Texas for a family of one at the time of application or reevaluation or earns more than this wage standard for a period of six months or longer in any Calendar Year and demonstrates that he/she is dependent on the Subscriber for care or support and either lives with the Subscriber or has care provided by the Subscriber on a regular basis.

A child who is at least 26 years of age on the date of and following the expiration of the child's continuation coverage under COBRA ceases to be a Dependent and may continue coverage as a Subscriber who is a Former COBRA Dependent Child.

A Former COBRA Dependent Child may enroll a newly acquired dependent child within 31 days of the child's date of birth or placement for adoption, but the Former COBRA Dependent Child may not enroll any other Dependents.

An eligible Dependent who lives outside of the Plan Service Area may elect to participate in the Out-of-State Plan even if the Subscriber, under whose coverage the Dependent is covered, participates in the In-Area Benefits Plan. If the Dependent returns to live in the Plan Service Area, he or she may elect to change participation to the In-Area Plan.

The Subscriber's Dependents may not enroll in a GBP health plan unless the Subscriber is also enrolled in a GBP health plan. The Subscriber and Dependents must be enrolled in the same health plan unless (i) the Subscriber and/or Dependents have different Medicare eligibility, or (ii) either the Subscriber or the Dependent enrolls in the HealthSelect Out-of-State plan because their county of residence or work on file with ERS is outside of the Plan Service Area. If the Subscriber and his/her Dependent are both eligible to enroll in a GBP health plan as the Subscriber, he/she may each be enrolled as the Subscriber or be covered as a Dependent of the other person's plan, but not both. In addition, if you and your spouse are both Subscribers under a GBP health plan, only one parent may enroll your child as a Dependent on this Plan.

Cost of Coverage

The Subscriber and his/her Employer may share in the cost of the Plan. The Subscriber contribution amount may depend on GBP eligibility and length of enrollment and whether the Subscriber chooses to enroll any Dependents.

The Subscriber's contributions are deducted from his/her paychecks or annuity checks depending on the elections chosen. If the Subscriber is receiving Retiree benefits, contributions are deducted from his/her annuity post-tax. If the Subscriber is receiving full-time employee benefits, then contributions are deducted from his/her paycheck on a pre-tax basis. This means contributions are deducted before tax dollars come out of the Subscriber's check, before federal income and Social Security taxes are withheld, and (in most states) before state and local taxes are withheld. This gives the Subscriber's contributions a special tax advantage and lowers the Subscriber's actual out-of-pocket costs. The amount of contributions is subject to review, and the Employees Retirement System of Texas Board of Trustees reserves the right to change the contribution amount from time to time.

You can obtain current contribution rates by calling your Benefits Coordinator or visiting **ers.texas.gov**.

How to Select Coverage

On your eligibility date, you are automatically enrolled in either the In-Area or Out-of-State Plan, depending on your eligibility county. If you do not want HealthSelect coverage, you must either select another coverage, if available, or waive coverage with your Benefits Coordinator, or online, on or before your eligibility date.

If your Employer is an Institution of Higher Education that participates in the GBP, as defined in Section 13, *Glossary*, and your Employer pays the contribution for your health coverage for the first 60 days of employment, you are automatically enrolled in either the In-Area or Out-of-State Plan, depending on your eligibility county, on the first day of Active Work. If you do not want HealthSelect coverage, you must either select another coverage, if available, or waive coverage with your Benefits Coordinator or online, on or before the 30th day of Active Work. The change in coverage is effective on the first day of the following month.

In order to enroll a Dependent, you must provide the Dependent information to your Benefits Coordinator on a Benefits Election Form and a Dependent Child Certification form online.

Important
If you wish to change your benefit elections following your marriage or the birth or adoption of a child, placement for adoption of a child or other family status change, you must contact your Benefits Coordinator, or make the change through ERS OnLine, within 31 days of the event. If the change in benefit elections is based on a change in Medicare or Medicaid status, or Children's Health Insurance Program (CHIP) status, you have 60 days. Otherwise, you will need to wait until the next Annual Enrollment period to change your elections. Retirees may drop their health plan coverage or change to a different GBP health plan coverage for which they are eligible at any time, with the coverage change effective the first of the month following the coverage change date.

When Coverage Begins

Once your Benefits Coordinator receives your properly completed enrollment information, coverage for Subscribers will begin as follows:

- if you are new to the Program or you have a break in Active Service, on the first day of the month following the completion of a 60-day waiting period, unless the 60th day falls on the first day of a month; in which case coverage begins that day;
- if you have previous Program health coverage with no break in Active Service, on the first day of Active Work or retirement; or
- if you are employed by an Institution of Higher Education on the first day of Active Work if your Employer pays for coverage during the waiting period; otherwise on the first day of the month following the completion of a 60-day waiting period, unless the 60th day falls on the first day of a month; in which case coverage begins that day.

Coverage for the Subscriber's eligible Dependents will begin as follows:

- if the Subscriber is eligible for coverage without a waiting period and the Subscriber's Dependent information is received on or before the Subscriber's first day of eligibility, coverage will be effective on the first day of eligibility. If the Subscriber's Dependent information is received within 31 days after the Subscriber's eligibility date, the coverage will become effective on the first day of the month following receipt of the Dependent information;
- if the Subscriber is subject to a waiting period and the Subscriber's Dependent information is received before the first day of the month after the 60-day waiting period, Dependent coverage will be effective on the first day of the month after the waiting period; or
- if the Subscriber's Dependent information is not received before these deadlines, then the Subscriber will need to wait until the next Annual Enrollment to add coverage for his or her eligible Dependents.

For eligible Dependents acquired after a Subscriber's eligibility date, or as addressed in the *Changing Your Coverage* subsection below, coverage will begin as follows:

NEWLY ACQUIRED DEPENDENT	DATE COVERAGE IS EFFECTIVE	ENROLLMENT NOTIFICATION REQUIREMENT*
Spouse or Dependent stepchild that the Subscriber acquires via marriage	The first of the month following the date of the marriage	Enroll within 31 days of the date of the marriage
Newborn natural child	At birth for 31 days without enrollment	Enroll within 31 days after the date of birth to continue the child's coverage
An eligible newborn who is not the Subscriber's natural child and meets the definition of Dependent of the Subscriber	The first of the month following the date of the birth	Enroll within 31 days of the date of the birth
An eligible child related by blood or marriage who is not the Subscriber's natural child and meets the definition of Dependent of the Subscriber	The first of the month following the date the child related by blood or marriage becomes a Dependent of the Subscriber	Enroll within 31 days of the date the child becomes a Dependent of the Subscriber
A child placed with the Subscriber for adoption	On the date of placement with the Subscriber for adoption	Enroll within 31 days of the placement for adoption
A foster child placed with the Subscriber	On the first day of the month following the date on which the foster child becomes a Dependent of the Subscriber	Enroll within 31 days of the date the foster child becomes a Dependent of the Subscriber
A child in possession of a Subscriber designated as managing conservator	On the first day of the month following the date on which the Subscriber is designated the child's managing conservator	Enroll within 31 days of the date the Subscriber is designated the child's managing conservator

NEWLY ACQUIRED DEPENDENT	DATE COVERAGE IS EFFECTIVE	ENROLLMENT NOTIFICATION REQUIREMENT*
An eligible Dependent who is the subject of a National Medical Support Notice	On the date a valid National Medical Support Notice is received by the Plan	Enroll within 31 days of the date of a valid National Medical Support Notice
An eligible child who is not the Subscriber's natural child, stepchild, child related by blood or marriage, adopted child, or foster child, and meets the definition of Dependent of the Subscriber	Effective the first of the month following the date the child becomes a Dependent of the Subscriber	Enroll within 31 days of the date the child becomes a Dependent of the Subscriber
An eligible Dependent who has lost eligibility for Medicaid or CHIP, or who has become eligible for premium assistance through Medicaid or the Health Insurance Premium Payment (HIPP) Program (HIPP)	On the first day of the month following the date on which the Dependent loses eligibility for Medicaid or CHIP, or becomes eligible for premium assistance through Medicaid or HIPP	Enroll within 60 days of the date the Dependent loses eligibility for Medicaid or CHIP, or becomes eligible for premium assistance through Medicaid or HIPP

The Subscriber must notify his/her Benefits Coordinator to enroll the newly acquired Dependent or enroll them through ERS OnLine, within the timeframe(s) provided in the table above. Verification of newly enrolled Dependent eligibility is required.

If You Are Hospitalized When Your Coverage Begins

If you are an Inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay beginning the first day of eligible coverage, as long as you receive Covered Health Services in accordance with the terms of the Plan.

It is recommended that your provider notify BCBSTX of your Inpatient hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible, to ensure you receive the appropriate level and duration of care. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity. Network Benefits are available only if you receive Covered Health Services from Network Providers.

Changing Your Coverage

You may make coverage changes during the Plan Year only if you experience a Qualifying Life Event (QLE), or during Annual Enrollment. The change in coverage must be consistent with the QLE (e.g., you cover your spouse following your marriage or your child following an adoption). The following are considered QLEs for purposes of the Plan:

- change in marital status;
- change in Dependent status;
- change in employment status;

- significant cost of Benefits or coverage change imposed by a third party;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- change of address that results in loss of coverage eligibility;
- change in Medicare, Medicaid, or Children's Health Insurance Program (CHIP) status; or
- an applicable National Medical Support Notice.

If you wish to change your elections, you must contact your Benefits Coordinator, or make the change through ERS OnLine, within 31 days of the QLE, If the change in benefits election is based on a change in Medicare, Medicaid or CHIP status, you have 60 days. Otherwise, you may not make a change until the next Annual Enrollment period. Retirees may drop their health plan coverage or change to a different GBP health plan coverage for which they are eligible at any time, with the coverage change effective the first of the month following the coverage change date.

Notes:

- Any child who is placed with the Subscriber for adoption will be eligible for coverage on the date the child is placed with the Subscriber, even if the legal adoption is not yet final.
- Any changes based on a QLE are effective on the first day of the month following the date of the QLE (except when a child is newborn, adopted or subject to a National Medical Support Order, as previously stated in this section).

Change in Coverage due to Qualifying Life Event – Example
Jane is married and has two children who are eligible Dependents. At Annual Enrollment, she elects not to participate in the GBP's health coverage because her husband, Tom, has family coverage under his employer's medical plan. In October, Tom loses his job due to downsizing. As a result, Tom loses his eligibility for health coverage. Because Tom's employment status changed, Jane can elect family health coverage under the GBP's health coverage outside of Annual Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes

- Accessing Benefits;
- BlueCard® Program and Beyond: Accessing Your Healthcare Benefits While Traveling;
- Allowable Amounts;
- Deductibles;
- Copay;
- Coinsurance;
- Inpatient Copay Maximum;
- Out-of-Pocket Coinsurance Maximum; and
- Total Network Out-of-Pocket Maximum.

Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits. Generally, when you receive Covered Health Services from a Network Provider, you pay less than you would if you receive the same care from a Non-Network Provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network Provider.

In most cases, if you receive care from Non-Network Providers, the Plan generally pays Benefits at a lower level and reimburses the Non-Network Provider at an amount less than a Network Provider. You may also be required to pay the amount that exceeds the Non-Network Allowable Amount (sometimes referred to as Balance Billing or Surprise Billing). Balance Billing can result in significant increased cost to you and this amount does not apply to any out-of-pocket maximum. It is very important that you ask the Non-Network Provider about his/her billed charges before you receive care. Emergency Services received at a Non-Network Hospital are covered at the Network level until your Physician determines that it is medically appropriate to transfer you to a Network Hospital.

Important Note:
When you choose to receive certain Covered Health Services from a Non-Network Provider, you are responsible for ensuring services will be covered under the Plan. This includes confirming Medical Necessity criteria are met. If you have questions about your Benefits, contact a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711), Monday–Friday 7 a.m. - 7 p.m. and Saturday 7 a.m. - 3 p.m. CT.

You should not be Balance Billed for any amounts above your Participant responsibility for Deductibles, Copayments and Coinsurance in the following instances:

- Emergency Services or supplies you receive from a Non-Network Provider;
- air ambulance services from Non-Network Providers;
- certain services from Non-Network Emergency Medical Services Providers;
- certain lab or diagnostic imaging services you receive from a Non-Network lab or diagnostic imaging service that were ordered by a Network Provider unless you agreed in writing in advance to receive the Non-Network services.

In certain non-emergency situations Non-Network Providers may ask you to sign a consent to waive your Balance Billing protections form. In these situations, the Provider must advise of:

- Provider's Non-Network status;
- a list of Network Providers at the Facility who could offer the same services (when services are received from a Non-Network Provider at a Network Facility);information about whether prior authorizations or limitations may be required in advance of services; and
- a good faith estimate of the Provider's charges.

  For more information on Surprise Billing see *Addendum – Your Rights and Protections Against Surprise Medical Bills Under the No Surprises Act and Texas Law.*

Important Note Regarding Balance Billing:
You are protected from Balance Billing (sometimes referred to as Surprise Billing) in emergency or certain other situations. For additional information regarding Balance Billing see the Addendum – Your Rights and Protections Against Surprise Medical Bills Under the No Surprises Act and Texas Law.

If you believe you've been wrongly billed without your advance consent, please contact a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711), or you may contact the CMS No Surprises Helpdesk by calling (800) 985-3059.

Network Benefits apply to Covered Health Services that are provided by a Network Specialist or coordinated through BCBSTX. Referrals to Specialists are not required under the HealthSelect Out-of-State Plan. Additionally, you do not need to designate a primary care provider (PCP) under the HealthSelect Out-of-State Plan.

Reminder: Stay in Network!
You should always confirm your Provider is contracting before you receive services. It's always a good idea to ask your Provider for the name(s) of the laboratories and Other Providers they use so that you can choose a Network Provider. This can significantly reduce your out-of-pocket expenses.

Emergency Services are always paid at the Network Benefit level regardless of whether services are received at a Network or Non-Network Hospital until your Physician determines that it is medically appropriate to transfer you to a Network Hospital. For more information on Emergency Services Benefits, including the difference in Benefits for Emergency Services received in a Hospital, a Freestanding Emergency Department or a Freestanding Emergency Room, go to Section 5, *Schedule of Benefits and Coverages* under the heading *Emergency Services*, and Section 6, *Details for Covered Health Services*. For more information about potential Balance Billing related to Emergency Services, and certain other non-emergency services, see the discussion of *Allowable Amounts* below in this Section 3, *How the Plan Works* and *Addendum – Your Rights and Protections Against Surprise Medical Bills Under the No Surprises Act and Texas Law.*

Network Benefits apply when Covered Health Services are provided by a Network Provider or Network Facility. Additionally, you are responsible for confirming that your Provider is a Network Provider before you receive services. If you have questions or need assistance locating a Network Provider, contact a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711) or by logging into your Blue Access for Members account at **healthselectoftexas.com**.

Non-Network Benefits apply to Covered Health Services that are provided by a Non-Network Provider or Non-Network Facility. Certain Non-Network services may also be subject to review for Medical Necessity and Plan limitations. It is recommended that your Provider request this review prior to rendering these services. See Section 4, *Recommended Clinical Review (RCR)*, for more information.

When Covered Health Services from Non-Network Providers Will Be Paid as Network

When Covered Health Services are not available from a Network Provider in your area, you may be eligible to receive Network Benefits from a Non-Network Provider. In such rare instances, your Provider will notify BCBSTX, and they will work with you and your Provider to authorize and coordinate care.

If a Network PCP or mental health professional is unavailable to provide care to a Participant within a 30-mile radius of the Participant's address on file, an exception must be authorized by BCBSTX in advance for the Participant to receive Network Benefits from a Non-Network PCP. If a Network Specialist is unavailable to provide care to a Participant within a 75-mile radius of the Participant's address on file, an exception must be authorized by BCBSTX in advance for the Participant to receive Network Benefits from a Non-Network Specialist.

When you receive Covered Health Services on this basis, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a Non-Network Provider.

Network Benefits also apply to Covered Health Services that are provided on a non-emergent basis at a Network Facility by a Non-Network emergency care Physician, assistant surgeon, surgical assistant, laboratory technician, radiologist, anesthesiologist, pathologist, consulting Physician, or other Provider acting under their scope of practice, as long as all other Plan requirements are met.

Claims that are provided on a non-emergent basis at a Network Facility by a Non-Network emergency care Physician, assistant surgeon, surgical assistant, laboratory technician, radiologist, anesthesiologist, pathologist, or consulting Physician will be reimbursed as set forth under Allowable Amounts as described in Section 13, *Glossary*.

- You may not be billed for the amount that exceeds your Participant responsibility for Deductibles, Copayments, and Coinsurance as part of the Allowable Amount, unless the Non-Network Provider has obtained your written consent in advance.

Looking for a Network Provider?
In addition to other helpful information, **healthselectoftexas.com**, HealthSelect's dedicated website, contains a directory of Network health care professionals and Facilities. While Network status may change from time to time, **healthselectoftexas.com** has the most current source of Network information. Use **healthselectoftexas.com** to search for Physicians available in your Plan.

Network Providers

BCBSTX or its affiliates arrange for health care Providers to participate in the Network. At your request, BCBSTX will send you a directory of Network Providers free of charge. Keep in mind, a Provider's Network status may change so the most up-to-date source of Network Providers is the HealthSelect dedicated website located online at **healthselectoftexas.com**. You may also contact a BCBSTX Personal Health Assistant, to verify a Provider's status or request a Provider directory, at (800) 252-8039 (TTY: 711).

Network Providers are independent practitioners and are not employees of HealthSelect, BCBSTX or ERS.

BlueCard® Program and Beyond: Accessing Your Healthcare Benefits While Traveling

Wherever you travel, you have access to healthcare Benefits.

If you are traveling outside of your state of residence but within the United States, the BlueCard Program provides access to Contracted Providers in other states. If you are traveling outside of the country, Blue Cross Blue Shield Global® Core provides access to Providers abroad.

Traveling Prepared

If you know you will be traveling, there are some things you can do to travel prepared.

- Call a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711), Monday–Friday 7 a.m. - 7 p.m. and Saturday 7 a.m. - 3 p.m. CT with any questions.
- Bring your medical ID card.
- If you receive care while traveling, keep all the associated receipts and paperwork.

How to Find a Provider

Finding a Provider while traveling is just like finding a Provider at home. You have a few options:

- **Call** a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711), Monday–Friday 7 a.m. - 7 p.m. and Saturday 7 a.m. - 3 p.m. CT.
- **Go online** to use the Provider Finder® tool.
    - For travel within the United States, Provider Finder is accessible via **healthselectoftexas.com** and by logging in to the secure Participant portal, Blue Access for Members℠.
    - For travel outside of the United States, the international Provider Finder is accessible via **bcbsglobalcore.com**.
- **Download** the BCBSTX Mobile App and use the Provider Finder tool. Text “BCBSTXAPP” to 33633 to get the app on your mobile device.

Emergency Care

In the event of an emergency, while you are traveling, visit the nearest emergency Facility.

The Plan pays Network Benefits for Covered Health Services, billed as Emergency Services, regardless of where you receive care. However, in some cases you may have to pay up front and file a claim to be reimbursed. Keep all your paperwork and follow the instructions for filing a claim below. For more information on Emergency Services Benefits, including the difference in Benefits cost for Emergency Services received in a Hospital, a Freestanding Emergency Department or a Freestanding Emergency Room, go to Section 5, *Schedule of Benefits and Coverages* under the heading *Emergency Services*, and Section 6, *Details for Covered Health Services*. For more information about potential Balance Billing related to Emergency Services, see the discussion of *Allowable Amounts* below in this Section 3, *How the Plan Works* and *Addendum –Your Rights and Protections Against Surprise Medical Bills Under the No Surprises Act and Texas Law*.

Non-Emergency Care

To visit a Provider for non-emergency care while traveling within the United States, find a Contracted Provider using the Provider Finder or by calling a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711).

It is recommended you contact a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711) to request an RCR for non-emergency Inpatient Services. See Section 4, *Recommended Clinical Review (RCR)*, for more information.

Traveling Within the United States

If you see a BlueCard Contracted Provider (verify via Provider Finder or calling a Personal Health Assistant) while traveling within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands, the Plan pays Network Benefits for Covered Health Services.

If you see a Non-Contracted Provider for non-emergency services, the Plan pays for Covered Health Services at the Non-Network Benefit level and subject to the Non-Network Annual Deductible. Generally, when you receive Covered Health Services from a Network Provider, you pay less than you would if you receive the same care from a Non-Network Provider.

Virtual Visits

If you are traveling within the United States, Virtual Visits are a convenient option for non-emergency care. Virtual Visits are services provided by a Virtual Network Provider for the diagnosis and treatment of low acuity, non-emergency conditions through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. A Virtual Visit is different from a Telemedicine visit, which is a Provider-platform visit. With a Virtual Visit from a Virtual Network Provider, you can speak to a board-certified Physician using live audio and video technology for treatment. If necessary, a Physician can prescribe medication and electronically send the prescription to your selected pharmacy. The service is available 24-hours a day, including nights, weekends and holidays. Virtual Visits are not available while traveling outside of the United States.

Traveling Outside the United States– Blue Cross Blue Shield Global® Core

If you see a Contracted Provider (verify via **bcbsglobalcore.com** or by calling a Personal Health Assistant) while traveling outside of the United States, the Plan pays for Covered Health Services at the Non-Network Benefit level and subject to the Non-Network Annual Deductible and Non-Network Plan provisions. If you see a Non-Network Provider, the Plan still pays for Covered Health Services at the Non-Network Benefit level and subject to the Non-Network Annual Deductible, but you could be Balance Billed.

How to Submit a Claim

If you visited a Non-Network Provider within the United States or any Provider outside of the United States, you'll likely need to submit a claim for reimbursement.

For care received within the United States, submit claims to Blue Cross and Blue Shield of Texas.

Submit the domestic claim form, found online at **healthselectoftexas.com**, with an itemized bill of services rendered. Please put your group and ID number on all pages of your submission.

Claims can be submitted by mail to:

Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, TX 75266-0044

For assistance with the claims submission process, call a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711), Monday–Friday 7 a.m. - 7 p.m. and Saturday 7 a.m. - 3 p.m. CT.

For care received abroad, submit claims to Service Center.

Send a completed Blue Cross Blue Shield Global Core claim form, found online at **bcbsglobalcore.com**, with an itemized bill of services rendered to the Global Core Service Center to begin the claims process.

Claims can be submitted by mail to:

Blue Cross Blue Shield Global Core Service Center
P.O. Box 2048
Southeastern, PA 19399

Claims also can be emailed to **claims@bcbsglobalcore.com**.

Following the instructions on the claim form will help ensure timely processing of your claim. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at (800) 810-BLUE (2583) 24 hours a day, 7 days a week.

Blue Cross, Blue Shield, the Blue Cross and Blue Shield symbols, BlueCard, and Blue Cross Blue Shield Global Core are trademarks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

Note: Whether you receive care within the United States or Outside of the United States, Participants have 18 months to submit a claim from the date of service. Providers have 365 days from the date of service to submit a claim. Claims received outside of this time frame will be denied.

Don't Forget Your HealthSelect Medical ID Card
Remember to show your HealthSelect medical ID card every time you receive Covered Health Services from a Provider. If you do not show your ID card, a Provider does not know that you are enrolled in the Plan and cannot determine your Benefits. If you forgot to pack your Medical ID Card, you can access a temporary card by logging into your Blue Access for Members account online or the BCBSTX App.

Allowable Amounts

Allowable Amounts are the maximum amounts, determined by BCBSTX, that the Plan could pay for Benefits for Covered Health Services while the Plan is in effect. The Plan payment reduces the Allowable Amount for any applicable Deductibles, Copayments, and/or Coinsurance amounts the Participant could be responsible for as indicated in Table 1 in Section 3, *How The Plan Works* and Tables 2 and 3 in Section 5, *Schedule of Benefits and Coverage.* Allowable Amount determinations are subject to BCBSTX' reimbursement policy guidelines, as described in *Addendum – Calculating Allowable Amounts*.

BCBSTX enters into agreements with Providers who agree to accept the Allowable Amount. When you use Contracted Providers, you are not responsible for the difference in the Allowable Amounts and the amount the Provider bills unless you've signed a written agreement with the Provider accepting financial responsibility. When you use Providers that are not in your Network, and you receive Non-Network Covered Health Services, the Plan will not pay Benefits until you have met your Annual Non-Network Deductible, and you may be responsible for paying, directly to the Non-Network Provider, any difference between the amount the Provider bills you and the Allowable Amount. This is also referred to as Balance Billing. For more information on how your share of the cost for Covered Health Services is impacted by using a Network or Non-Network Provider, see *Accessing Benefits* in this Section 3, *How The Plan Works.*

To find an estimate of your share of the cost for health care services or procedures before you go to the Physician or Hospital, log in to your Blue Access for Members account online at **healthselectoftexas.com** and search for specific procedures within the HealthSelect Provider Finder. You can also call a BCBSTX Personal Health Assistant toll-free at (800) 252–8039 (TTY: 711) for help.

Reminder
An Explanation of Benefits (EOB) will be provided to you for claims processed by BCBSTX and will show you the Allowable Amount, any amounts paid by the Plan, and the amount you are responsible for. If your claim is denied in whole or in part, the EOB will include the reason for the denial or partial payment. Please note that your EOB will not reflect amounts you may have already paid to the Provider.

ERS has delegated to BCBSTX the discretion to determine whether a treatment or supply is a Covered Health Service and how the Allowable Amounts will be determined and otherwise covered under the Plan, per guidelines established by the Plan and BCBSTX. ERS has the discretion to interpret all terms and conditions under the Plan, as described under *Interpretation of the Plan* in Section 12, *Other Important Information*.

For information regarding how the Allowable Amount is determined see the *Addendum - Calculating Allowable Amounts.*

Important
In general, a Non-Network Allowable Amount is less than a Network Allowable Amount. This means the Plan will usually pay less towards Non-Network Covered Health Services than Network Covered Health Services. When you receive Covered Health Services from a Non-Network Provider, your cost is generally higher because you may be responsible for the amount exceeding the Plan's Allowable Amount. (This is referred to as Balance Billing). For example, this may apply if you receive Covered Health Services at a Non-Network Facility or from a Non-Network Provider. See Section 3, *How the Plan Works*, under the heading *Accessing Benefits* for more information on Balance Billing and when it may apply.

Deductibles

Annual Non-Network Deductible

The Annual Non-Network Deductible is the portion of the Allowable Amounts you must pay each Calendar Year for Covered Health Services before you are eligible to begin receiving Non-Network Benefits.

Covered Health Services that are subject to the Annual Non-Network Deductible and also subject to a visit or day limit will be included in reaching both the Annual Non-Network Deductible and the maximum day or visit Benefit limit.

The Annual Non-Network Deductible for each Participant is $500, with a family maximum of $1,500 per Calendar Year. However, if two or more Participants who are covered by the same Subscriber are injured in the same accident, the family maximum will not apply. Instead, only one Participant's Non-Network Deductible is required for the Calendar Year in which the accident occurred.

Bariatric Deductible

The separate Bariatric Deductible is the amount an Employee must pay for Bariatric Surgery before becoming eligible to begin receiving Network Benefits for such surgery. There is no coverage for Bariatric Surgery provided by a Non-Network Provider. Additionally, the Bariatric Surgery Benefit is not available to Retirees or Dependents.

The separate Bariatric Deductible is $5,000.

Allowable Amounts that apply to the separate Bariatric Deductible do not apply to the Out-of-Pocket Coinsurance Maximum or Total Out-of-Pocket Maximum.

Note: For a complete description of guidelines and coverage for Bariatric Surgery, including the lifetime maximum benefit amount, refer to Section 5, *Schedule of Benefits and Coverage*, and Section 6, *Details for Covered Health Services*, under the heading *Bariatric Surgery*.

Copay

A Copay is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the Provider. If the Allowable Amount is less than the Copay, you are only responsible for paying the Allowable Amount and not the Copay.

Copays do not count toward the Out-of-Pocket Coinsurance Maximum nor toward the Annual Non-Network Deductible. However, Copays count toward the Total Out-of-Pocket Maximum.

Coinsurance

Coinsurance is a fixed percentage of Allowable Amounts that you are responsible for paying for certain Covered Health Services. The amount you pay for Coinsurance for Network Covered Health Services received is determined after you pay any applicable Copays. For Non-Network Covered Health Services, the amount you pay for Coinsurance is determined after you meet the Annual Non-Network Deductible and pay any applicable Copays.

The payments you make as Coinsurance apply to your Out-of-Pocket Coinsurance Maximum.

Examples
Coinsurance: Let's assume that you receive Plan Benefits for Durable Medical Equipment from a Network Provider. Since the Plan pays 80% of Allowable Amounts, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Copay: Let's assume that you receive Plan Benefits for Physician's Office Services from a Network Specialist. Your Specialist Copay is $40, and the Plan pays 100% of Allowable Amounts after you pay the Copay.

Inpatient Copay Maximum

The annual Inpatient Copay Maximum is the most you pay each Calendar Year in Copays for Inpatient Stays in a Hospital or other Facility. There is a combined Network and Non-Network Inpatient Copay Maximum for this Plan. Once you reach the applicable Inpatient Copay Maximum, you are not required to pay any more Inpatient Copays for the remainder of the Calendar Year.

When you pay any Inpatient Copay for a Network or Non-Network Inpatient Stay, it applies toward the Inpatient Copay Maximum.

The Inpatient Copay Maximum is separate from the Plan Out-of-Pocket Coinsurance Maximum. However, Copays for Inpatient Stays that apply to the Inpatient Copay Maximum also apply to the Total Out-of-Pocket Maximum.

Out-of-Pocket Coinsurance Maximum

The annual Out-of-Pocket Coinsurance Maximum is the most you pay for Coinsurance each Calendar Year for Covered Health Services. There are separate Network and Non-Network Out-of-Pocket Coinsurance Maximums for this Plan. Once you reach the applicable Out-of-Pocket Coinsurance Maximum, you will not be required to pay any more Coinsurance for the remainder of the Calendar Year, except as noted below.

If your eligible out-of-pocket Coinsurance expenses, except as noted below, in a Calendar Year exceed the Out-of-Pocket Coinsurance Maximum, the Plan pays 100% of Allowable Amounts, not including Copays, for Covered Health Services through the end of the Calendar Year.

Exceptions: Benefits for Bariatric Surgery are not paid at 100% even after the Out-of-Pocket Coinsurance Maximum is reached. The Plan will continue to pay Bariatric Surgery at 80% for Network Benefits (Non-Network Benefits are not covered).

Table 1 below identifies what does and does not apply toward your Out-of-Pocket Coinsurance Maximum.

Total Network Out-of-Pocket Maximum

The Total Network Out-of-Pocket Maximum is the most you are required to pay each Calendar Year for both Network Prescription Drug and Network medical benefits including: Annual Deductibles, Copays, and Coinsurance (medical benefits only), as detailed in Section 5, *Schedule of Benefits and Coverage*. Refer to Section 3, *How the Plan Works*, for a description of how the Total Network Out-of-Pocket Maximum works.

Once you reach the Total Network Out-of-Pocket Maximum, you will not be required to pay any more out-of-pocket expenses for Network Benefits for the remainder of the Calendar Year, except as noted below. ***Note:*** See Table 1 below and Table 2 in Section 5, *Schedule of Benefits and Coverage*, for details on what applies to the Total Network Out-of-Pocket Maximum.

If your eligible out-of-pocket expenses in a Calendar Year exceed the Total Network Out-of-Pocket Maximum, except as noted below, the Plan pays 100% of Allowable Amounts for Covered Health Services for that level of Benefits through the end of the Calendar Year.

Exceptions: Benefits for Bariatric Surgery are not paid at 100% even after the Total Network Out-of-Pocket Maximum is reached. The Plan will continue to pay Bariatric Surgery at 80% for Network Benefits (Non-Network Benefits are not covered).

Table 1 below identifies what does and does not apply toward your Total Network Out-of-Pocket Maximum.

TABLE 1			
Plan Features	**Applies to the Network Out-of-Pocket Coinsurance Maximum?**	**Applies to the Total Network Out-of-Pocket Maximum?**	**Applies to the Non-Network Out-of-Pocket Coinsurance Maximum?**
Copays, including those that apply to the Inpatient Copay Maximum	No	Yes	No
Payments toward the Annual Non-Network Deductible	Not Applicable	Not Applicable	No
Payments toward the Network separate Bariatric Deductible	No	No	Not Applicable
Coinsurance payments for Bariatric Surgery	No	No	Not Applicable
Coinsurance payments for all other Covered Health Services	Yes	Yes	Yes
Services or supplies that are for non-covered Health Services excluded under the Plan	No	No	No
Expenses not covered because a maximum Benefit has been reached	No	No	No
Charges that exceed Allowable Amounts as determined by BCBSTX	No	No	No

How the Plan Works – Example

The following example illustrates how Annual Non-Network Deductibles, Copays and Out-of-Pocket Coinsurance Maximums, Total Network Out-of-Pocket Maximum and Coinsurance work in practice: Let's say Gary has individual coverage under the Plan. He has met his Annual Non-Network Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Provider versus a Non-Network Provider.

Network Benefits	Non-Network Benefits
1. Gary goes to see his Network Primary Care Provider and presents his HealthSelect medical ID card.	1. Gary goes to see a Non-Network Provider and presents his HealthSelect medical ID card.
2. He receives treatment from his Primary Care Provider. The Plan's Allowable Amount for the Network office visit equals $125.	2. He receives treatment from the Provider. The Allowable Amount for his visit to his Non-Network Provider is $85; however, the Physician's fee is $225.
3. On his way out, Gary pays a $25 Primary Care Provider Copay. Since Network Primary Care Provider office visits are covered at 100% after the Copay, Gary does not pay any Coinsurance and he has met his financial obligations for this office visit.	3. The Physician's office requests no payment, informing Gary that it will bill BCBSTX directly. *
4. The Plan pays $100 ($125 Allowable Amount minus the $25 Copay).	4. Since Gary has met his Non-Network Annual Deductible, he is responsible for paying Coinsurance for this visit. After BCBSTX processes the claim from the Provider, it is determined that Gary is responsible for paying Coinsurance directly to the Physician. Gary is responsible for $34 (40% of $85).
5. BCBSTX applies the $25 toward Gary's Total Network Out-of-Pocket Maximum.	5. Gary receives a bill from the Physician for the $34 and pays the Physician directly. BCBSTX pays $51 to the Physician (60% of $85).

6. The Physician's office, at its discretion, might bill Gary for the remaining $140 (sometimes referred to as Balance Billing):

$225	-	$85	=	$140
(Physician's fee)		(Allowable Amount)		

Gary's $140 payment does not apply to his Non-Network Out-of-Pocket Coinsurance Maximum.

*Although Non-Network Providers have the right to request payment in full at the time of service, they bill BCBSTX directly in most cases.

SECTION 4 - RECOMMENDED CLINICAL REVIEW (RCR)

What this section includes

- Information about RCR for certain Covered Health Services; and
- Services included in the RCR process.

Recommended Clinical Review (RCR)

The Plan does not require prior authorization for any Covered Health Services. It is recommended your Provider submit an RCR request to BCBSTX to confirm coverage, limitations, and Medical Necessity prior to rendering the Covered Health Services listed below.

If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

In general, Network Providers are responsible for ensuring services they provide meet Medical Necessity criteria.

When you choose to receive certain Covered Health Services from a Non-Network Provider, you are responsible for ensuring services will be covered under the Plan. This includes confirming Medical Necessity criteria are met.

BCBSTX will review the services and will determine the appropriate setting for treatment. If an Inpatient Stay is required, your Provider may work with BCBSTX to ensure the stay is for the appropriate level of care and duration. Inpatient Stays are covered on a Semi-private Room basis.

Covered Health Services for which pre-service clinical review is recommended are identified below and in Section 6, *Details for Covered Health Services*, within each Covered Health Service category.

It is your responsibility to ensure all required eligibility and coverage limitations are met.

In the event a pre-service RCR or a post-service clinical review determines the service is not covered, you have the right to file an appeal as described in Section 8, *Claims Procedures* under the heading *Claim Denials and Appeals*.

Before receiving these services from a Provider, you may want to contact BCBSTX to determine whether the Hospital, Physician and Other Providers are current Network Providers and if so, that they have obtained pre-service clinical review. Network Facilities and Network Providers cannot bill you for services that do not meet Medical Necessity criteria. To verify that a Provider is in Network or to check the status of a pre-service clinical review, you may contact BCBSTX at (800) 252-8039 (TTY: 711). You can also go online to **healthselectoftexas.com** and log in to Blue Access for Members to view your pre-service approvals.

When you choose to receive certain Covered Health Services from Non-Network Providers, you are responsible for ensuring services will be covered under the Plan. This includes confirming Plan requirements and Medical Necessity criteria are met.

To confirm your service will be covered prior to receiving care, call BCBSTX at (800) 252-8039 (TTY: 711). This call starts the RCR process. The RCR process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Once you have obtained the pre-service approval, please review the documentation carefully so that you understand the approved services and which Providers are approved to deliver the approved services.

Covered Health Services Recommended for Pre-Service Clinical Review

It is recommended that your Provider submit an RCR request to BCBSTX to confirm coverage, limitations, and Medical Necessity prior to rendering the Covered Health Services listed below. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

In the event a pre-service RCR or a post-service clinical review, determines the service is not covered, you have the right to file an appeal as described in Section 8, *Claims Procedures* under the heading *Claim Denials and Appeals*.

- advanced imaging/radiology, cardiology (such as CT scan, Nuclear Stress Test, MRI, PET scan), with the exception of MRI of the breast;
- Applied Behavior Analysis (ABA);
- Bariatric Surgery;
- elective Behavioral Health and Chemical Dependency Facility admissions: Inpatient and Residential Treatment Center;
- home health services;
- home infusion therapy (only covered for Network Providers);
- Inpatient admissions;
- Inpatient Hospice and rehabilitation;
- Intensive Outpatient Program (IOP) for Mental Health Services and Substance Use Disorder;
- long-term acute care;
- maternity Inpatient care (for deliveries with complications);
- medical oncology & supportive care;
- molecular genetic lab testing;
- NICU Inpatient care;
- non-emergent air and ground ambulance;
- Outpatient surgery:
    - cardiology-lipid apheresis;
    - ear, nose and throat (ENT);
    - for deactivation of headache triggers;
    - gastroenterology;
    - neurological;
    - of the breast;
    - of the jaw; and
    - wound care;
- Partial Hospitalization Program (PHP)/Day Treatment;
- Private Duty Nursing;
- provider administered drug therapy, obtained through BCBSTX (contact a BCBSTX Personal Health Assistant for additional information);

- radiation therapy/radiation oncology;
- repetitive transcranial magnetic stimulation (rTMS);
- Skilled Nursing Facility;
- sleep studies; and
- transplant services.

If you have questions about Covered Health Services and the RCR process, simply call a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711) Monday–Friday 7 a.m. - 7 p.m. and Saturday 7 a.m. - 3 p.m. CT.

SECTION 5 - SCHEDULE OF BENEFITS AND COVERAGE

Table 2 below contains the Plan's Copays, Annual Non-Network Deductible, other deductibles, and maximums applicable for Covered Health Services.

TABLE 2		
Plan Features	**Network**	**Non-Network**
Copays[1] (Copay is per visit unless otherwise stated)		
• Emergency Room Services	$150	$150
• Freestanding Emergency Room (FSER not affiliated with Hospital)	$150	$150
• Freestanding Emergency Department - (FSER Department that is Hospital-affiliated)	$150	$150
• High-Tech Radiology - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	$100	$100
• Hospital or other Facility - Inpatient Stay (Copay is per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year*)	$150	$150
*If you are discharged and then readmitted to any Hospital within 24 hours for the same condition, the Copays you paid for the initial admission are combined with the Copay(s) for the readmission to reach the per-admission maximum.		
• Physician's Office Services - PCP	$25	Not Applicable[2]
• Physician's Office Services - Specialist	$40	Not Applicable[2]
• Mental Health or Substance Disorder Office Services	$25	Not Applicable[2]
• Retail Health Clinic	$25	Not Applicable[2]

TABLE 2 (Cont'd)		
Plan Features	**Network**	**Non-Network**
Copays[1] (Cont'd) (Copay is per visit unless otherwise stated)		
• Surgery - Outpatient (Copay is per day or visit)	$100	$100
• Urgent Care Center Services	$50	Not Applicable[2]
• Virtual Visits	$0	Not Covered
Annual Non-Network Deductible[3, 4]		
• Participant, per Calendar Year	Not Applicable	$500
• Family, per Calendar Year (not to exceed the applicable Individual amount per Participant for Non-Network Benefits)	Not Applicable	$1,500
Separate Bariatric Deductible[5]	$5,000	Not Covered
Out-of-Pocket Coinsurance Maximum[6] per Calendar Year, per Participant	$2,000	$7,000
Inpatient Copay Maximum[7] per Calendar Year, per Participant	$2,250	
Total Network Out-of-Pocket Maximum[8]		
• Participant, per Calendar Year	Effective 1/1/24-12/31/24: $7,500 Effective 1/1/25: $8,050	Not Applicable[9]
• Family, per Calendar Year (not to exceed the applicable Individual amount per Participant for Network Benefits)	Effective 1/1/24-12/31/24: $15,000 Effective 1/1/25: $16,100	Not Applicable[9]
Lifetime Maximum Benefit	Unlimited	

[1]Copays do not apply toward the Deductible or Out-of-Pocket Coinsurance Maximum. However, Copays apply toward the Total Network Out-of-Pocket Maximum.

[2]Coinsurance applies to this Benefit. See Table 3 below for details.

[3]The Annual Non-Network Deductible does not apply toward the Out-of-Pocket Coinsurance Maximum for any Covered Health Services.

[4]If two or more Participants who are covered by the same Subscriber are injured in the same accident, the family Non-Network Annual Deductible will not apply. Instead, only one Participant's Non-Network Annual Deductible is required for the Calendar Year in which the accident occurred.

[5]The Separate Bariatric Deductible does not apply to the Network Out-of-Pocket Coinsurance Maximum or to the Total Network Out-of-Pocket Maximum.

[6]The Network Out-of-Pocket Coinsurance Maximum accumulates separately from the Non-Network Out-of-Pocket Coinsurance Maximum.

[7]The Inpatient Copay Maximum is separate from the Out-of-Pocket Coinsurance Maximum. Copays for Inpatient Stays that apply to the Inpatient Copay Maximum also apply to the Total Network Out-of-Pocket Maximum.

[8]The Total Network Out-of-Pocket Maximum includes the Network Out-of-Pocket Coinsurance Maximum of $2,000, the Inpatient Copay Maximum of $2,250 and any other Copays.

[9]There is no Total Out-of-Pocket Maximum for Non-Network Benefits.

This Table 3 contains the percentages of the Allowable Amount paid by the Plan pays for the Covered Health Services listed. You are responsible for the Coinsurance, which is the percentage of Allowable Amounts not paid by the Plan. For detailed descriptions of Covered Health Services and Benefits, refer to Section 6, *Details for Covered Health Services*.

Important
In general, a Non-Network Allowable Amount is less than a Network Allowable Amount. This means the Plan will generally pay less toward Non-Network Covered Health Services than Network Covered Health Services. If you receive Covered Health Services from a Non-Network Provider, your cost is generally higher because you may be responsible for the amount exceeding the Plan's Allowable Amount, which can be significantly more than when you receive Covered Health Services from a Network Provider. (This is referred to as Balance Billing.) This may also apply if you receive Covered Health Services at a Network Facility from a Non-Network Provider on a non-emergent basis. See Section 3, *How the Plan Works*, under the heading *Accessing Benefits* for more information on Balance Billing and when it may apply.

TABLE 3		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Acquired Brain Injury		
Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: $40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	*All Physicians* 60% after you meet the Annual Non-Network Deductible
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Physician Fees for Covered Services	80%	60% after you meet the Annual Non-Network Deductible
• Rehabilitation Services - Outpatient Therapy	80%	60% after you meet the Annual Non-Network Deductible
Allergy Treatment	*Administered in a Physician's office* 100% *Administered in any other Outpatient location* 80%	60% after you meet the Annual Non-Network Deductible
Ambulance Services (Emergency and Non-Emergency)	80%	80% Annual Non-Network Deductible does not apply

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Bariatric Surgery (for Active Employees only, not Dependents) You must pay a $5,000 separate Bariatric Deductible specific to Bariatric Surgery before the Plan pays Benefits. One surgery and maximum Benefits of $13,000 per lifetime. ***Note:*** **Bariatric Surgery is only covered at a Blue Distinction Center**		
Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: $40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	Not Covered
• Physician Fees for Covered Services	80%*	Not Covered
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80%* after you pay the Copay	Not Covered
• Lab and X-Ray	80%*	Not Covered
*Coinsurance for Bariatric Surgery does not apply to the Out-of-Pocket Coinsurance Maximum or Total Network Out-of-Pocket Maximum.		

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Chiropractic Treatment Maximum Benefits of $75 per visit and maximum of 30 visits per Calendar Year. Copay is $40 per visit for chiropractic office visit. (Copay for Airrosti Providers is $25 per visit and maximum of 30 visits per Calendar Year. Maximum Benefit of $75 per visit does not apply to Airrosti Providers.)	*For office visits:* 100% after you pay the Copay *For all other services in the office in an Outpatient setting:* 80%	60% after you meet the Annual Non-Network Deductible
Clinical Trials		
Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: 40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	*All Physicians* 60% after you meet the Annual Non-Network Deductible
• Hospital - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Physician Fees for Surgical and Medical Services	80%	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Congenital Heart Disease (CHD) Services		
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: $40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	*All Physicians* 60% after you meet the Annual Non-Network Deductible
• Physician Fees for Covered Services	80%	60% after you meet the Annual Non-Network Deductible
• Scopic Procedures - Outpatient Diagnostic and Therapeutic	80%	60% after you meet the Annual Non-Network Deductible
• Surgery - Outpatient (Copay is $100 per surgery)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Dental Services		
• Dental Anesthesia	80%	60% after you meet the Annual Non-Network Deductible
• Accident-Related	80%	80% Annual Non-Network Deductible does not apply
• Medical Condition-Related	80%	60% after you meet the Annual Non-Network Deductible
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Surgery - Outpatient (Copay is $100 per surgery)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Diabetes Services See *Durable Medical Equipment in Section 6, Details for Covered Health Services,* for limits.		
• Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care		
Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: $40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	*All Physicians* 60% after you meet the Annual Non-Network Deductible
• Diagnostic A1c Testing for Participants diagnosed with diabetes	80%	60% after you meet the Annual Non-Network Deductible
• Diabetes Items		
○ Diabetic equipment that is an insulin pump or continuous glucose monitor prescribed by a Physician	80%	60% after you meet the Annual Non-Network Deductible
○ Diabetes supplies Diabetic supplies used exclusively with a Provider-prescribed insulin pump or continuous glucose monitor.	80%	80% Annual Non-Network Deductible does not apply
Durable Medical Equipment (DME)	80%	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Emergency Services		
• Hospital Emergency Room - Outpatient		
○ Emergency (Copay is $150 per visit) ***Note:*** The Emergency Room Copay is waived if you are admitted as an Inpatient directly from the Emergency Room. Your Covered Health Services will be considered under the Hospital or other Facility - Inpatient Stay instead.	80% after you pay the $150 Copay	80% after you pay $150 Copay Annual Non-Network Deductible does not apply
○ Non-Emergency	80% after you pay the $150 Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Freestanding Emergency Room (FSER not affiliated with Hospital)		
○ Emergency ***Note***: The Emergency Room Copay is waived if you are admitted as an Inpatient directly from the Emergency Room. Your Covered Health Services will be considered under the Hospital or other Facility - Inpatient Stay instead.	80% after you pay the $150 Copay	80% after $300 the Copay Annual Non-Network Deductible does not apply
○ Non-Emergency	80% after you pay the $150 Copay	60% after you pay the $300 Copay and meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Emergency Services (Cont'd)		
• Freestanding Emergency Department – (FSER Department that is Hospital-affiliated)		
○ Emergency	80% after you pay the $150 Copay	80% after $150 Copay Annual Non-Network Deductible does not apply
○ Non-Emergency	80% after you pay the $150 Copay	60% after you pay the $150 Copay and meet the Annual Non-Network Deductible
• **Facility-Based Providers** (includes Radiologists, Anesthesiologists, Pathologists and Labs, and Emergency Room Physicians, and could include other Facility-based Providers)		
○ Emergency	80%	80% Annual Non-Network Deductible does not apply

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Emergency Services (Cont'd)		
○ Non-Emergency* *For Non-Network Facility-Based Providers that practice in a Network Facility, Network Benefits apply to the Participant; but Plan reimbursement to the Non-Network Hospital-Based Provider is at the Non-Network level. For Non-Network Facility-Based Providers that practice in a Non-Network Facility, Non-Network Benefits apply, See Section 3, *How the Plan Works*, under the heading *Accessing Benefits* for more information on Balance Billing and when it may apply to Non-Network Facility-Based Providers.	80%	60% after you meet the Annual Non-Network Deductible
Family Planning and Infertility Services		
• FDA-approved women's contraception methods, voluntary sterilization and contraceptive counseling	100%	60% after you meet the Annual Non-Network Deductible
• All other family planning services and supplies	80%	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Habilitation and Rehabilitation Services - Outpatient Therapy (including physical therapy, occupational therapy, and speech therapy)	80%	60% after you meet the Annual Non-Network Deductible
Hearing Aids Requiring a Prescription Maximum Benefits of $1,000 per ear for any consecutive 36-month period and for the hearing aid requiring a prescription, $1 per battery. (The $1,000 maximum does not apply to hearing aids for Participants 18 years of age and younger)	100%	100% of billed amount up to benefit maximum Annual Non-Network Deductible does not apply
High-Tech Radiology - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient (Copay is $100 per visit)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
Home Health Care		
• Home infusion therapy	80%	Not Covered
• All other home health care services	80%	60% after you meet the Annual Non-Network Deductible Maximum of 100 visits per Calendar Year for Non-Network Benefits. Both Network and Non-Network visits apply to this maximum.
Hospice Care	80%	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
Lab, X-Ray and Diagnostics – Outpatient See Section 3, *How the Plan Works*, under the heading *Accessing Benefits* for more information on Balance Billing and when it may apply to Non-Network lab and diagnostic imaging services.	80%	60% after you meet the Annual Non-Network Deductible
Mammogram - Diagnostic	100%	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Maternity Care		
• Physician's Services No Copay or Coinsurance applies to Network prenatal visits and to Network obstetrician delivery services. Complications of Pregnancy are treated as Physician's Office Services - Sickness and Injury.	100%	*All Physicians* 60% after you meet the Annual Non-Network Deductible
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year) A separate Copay, Coinsurance and Deductible will not apply for a newborn child's Hospital stay unless the child's length of stay in the Hospital exceeds the mother's or unless the mother is not a HealthSelect Plan Participant.	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Physician Fees for Covered Services (Non-obstetric services)	80%	60% after you meet the Annual Non-Network Deductible
• Lab, X-Ray and Diagnostics – Outpatient See Section 3, *How the Plan Works*, under the heading *Accessing Benefits* for more information on Balance Billing and when it may apply to Non-Network lab and diagnostic imaging services.	80%* *If the services are billed by the Provider as preventive, coverage will be at 100%.	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Medical Supplies	80%	60% after you meet the Annual Non-Network Deductible
Medications and Injections (Copay is $25 per visit for PCP or $40 per visit for Specialist if administered during Physician's office visit) ***Note:*** Medications and Injections that are preventive in nature are covered as shown under *Preventive Care Services* in this section. Outpatient prescription medications may be covered under the HealthSelect Prescription Drug Program (PDP).	*Administered in a Physician's office* 100% after you pay the Copay* *Administered in any other Outpatient location* 80% *Covered at 100% if no office visit charge is assessed.	*Administered in a Participant's home* Not Covered *Administered in any other Outpatient location* 60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Neurobiological Disorders - Autism Spectrum Disorder Services		
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Outpatient Facility Care (Partial Hospitalization Program (PHP)/Day Treatment and Intensive Outpatient Program (IOP))	80%	60% after you meet the Annual Non-Network Deductible
• Outpatient Physician or Mental Health Provider Services (Copay is $25 per visit)	100% after you pay the Copay	60% after you meet the Annual Non-Network Deductible
• Applied Behavioral Analysis (ABA) treatment See *Neurological Disorders-Autism Spectrum Disorder Services* in Section 6, *Details for Covered Health Services*, for more details.	*Administered in Provider's office* 100% after you pay the $25 Copay *Administered in any other Outpatient location, including the home* 80%	60% after you meet the Annual Non-Network Deductible
Nutritional Counseling Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: $40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	*All Physicians* 60% after you meet the Annual Non-Network Deductible
Ostomy Supplies	80%	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Physician Fees for Covered Services (includes services for Second Opinion)	80%	60% after you meet the Annual Non-Network Deductible
Physician's Office Services - Sickness and Injury (Diagnostic) (includes services for Second Opinion)		
• PCP: $25/visit • Specialist: $40/visit • Network obstetrician or gynecologist: $40/visit	100% after you pay the Copay*	60% after you meet the Annual Non-Network Deductible
*No Copay applies when a Physician's charge is not assessed		
• Outpatient Clinic Facility Services	80%	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Physician's Office Services - Sickness and Injury (Diagnostic) (includes services for Second Opinion) (Cont'd)		
• In addition to the Copay stated in this section, the Copays or Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed in a Physician's office: • high-tech radiology and nuclear medicine described under *High-Tech Radiology - CT, PET, MRI, MRA and Nuclear Medicine* – Outpatient; • diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic.*		
• Lab, X-Ray and Diagnostics – Outpatient	80%* *If these services are billed by the Provider as preventive, coverage will be at 100%.	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Preventive Care Services • Prostate cancer (PSA) screening for men (See chart for the USPSTF List in the *Addendum – List of Covered Preventive Care Services*.) • ***Note:*** Under the Affordable Care Act, certain Preventive Care Services are paid at 100% (i.e., at no cost to the Participant) conditioned upon Physician billing and diagnosis. In some cases, you may be responsible for payment on certain related services, such as diagnostic services and/or services provided by a Non-Network Provider, that are not guaranteed payment at 100% by the Affordable Care Act.	100%	60% after you meet the Annual Non-Network Deductible
Private Duty Nursing - Outpatient	80%	60% after you meet the Annual Non-Network Deductible Maximum of 96 hours per Calendar Year for Non-Network Benefits

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Prosthetic Devices		
• Cranial Hair Prosthetics (wigs) are limited to a lifetime benefit up to $1,000.	80%	80% of billed amount up to Benefit maximum Annual Non-Network Deductible does not apply
• All other prosthetic devices	80%	60% after you meet the Annual Non-Network Deductible
Reconstructive Procedures		
Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: $40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	*All Physicians* 60% after you meet the Annual Non-Network Deductible
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Physician Fees for Covered Services	80%	60% after you meet the Annual Non-Network Deductible
• Prosthetic Devices	80%	60% after you meet the Annual Non-Network Deductible
• Surgery – Outpatient (Copay is $100 per surgery)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Retail Health Clinic Copay: $25/visit	100% after you pay the Copay	60% after you meet the Annual Non-Network Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80%	60% after you meet the Annual Non-Network Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	80%	60% after you meet the Annual Non-Network Deductible
Substance Use Disorder Services		
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Outpatient Facility Care (Partial Hospitalization Program (PHP)/Day Treatment and Intensive Outpatient Program (IOP))	80%	60% after you meet the Annual Non-Network Deductible
• Outpatient Physician or Mental Health Provider Services Copay: $25/visit	100% after you pay the Copay	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Surgery - Outpatient (Copay is $100 per surgery)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
Telemedicine Visits - Sickness and Injury		
• PCP Telemedicine visit Copay: $25/visit • Mental Health Provider Telemedicine visit Copay: $25/visit	100% after you pay the Copay*	60% after you meet the Annual Non-Network Deductible
• Specialist Telemedicine visit Copay: $40/visit • Network obstetrician or gynecologist Telemedicine visit Copay: $40/visit	100% after you pay the Copay*	60% after you meet the Annual Non-Network Deductible
*No Copay applies when a Physician's charge is not assessed Telemedicine visits for Covered Health Services are covered at the same Benefits as in-person visits for the services listed throughout this Schedule of Benefits. (So, for example, Telemedicine visit Benefits for Preventive Care Services can be located under the heading Preventive Care Services in this chart.)		

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Temporomandibular Joint (TMJ) Services and Orthognathic Surgery		
Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: $40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	*All Physicians* 60% after you meet the Annual Non-Network Deductible
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Physician Fees for Covered Services	80%	60% after you meet the Annual Non-Network Deductible
• Surgery - Outpatient (Copay is $100 per surgery)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
Therapeutic Treatments - Outpatient	80%	60% after you meet the Annual Non-Network Deductible

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Transplant Services		
Physician's Office Services • PCP Copay: $25/visit or • Specialist Copay: $40/visit	*PCP* 100% after you pay the Copay *Specialist* 100% after you pay the Copay	*All Physicians* 60% after you meet the Annual Non-Network Deductible
• Hospital or other Facility - Inpatient Stay (Copay is $150 per day, up to a maximum of $750 per admission and a maximum of $2,250 per Calendar Year)	80% after you pay the Copay	60% after you pay the Copay and after you meet the Annual Non-Network Deductible
• Physician Fees for Covered Services	80%	60% after you meet the Annual Non-Network Deductible
Urgent Care Center Services (Copay is $50 per visit)	80% after you pay the Copay	60% after you meet the Annual Non-Network Deductible
Virtual Visits using a Virtual Network Provider Benefits are available only when services are delivered through a Virtual Network Provider. You can find a Virtual Network Provider at **healthselectoftexas.com** or by calling BCBSTX at (800) 252-8039 (TTY: 711).	100%	Not Covered

TABLE 3 (Cont'd)		
Covered Health Services[1]	**Percentage of Allowable Amounts Payable by the Plan:**	
	Network	**Non-Network***
Vision Examinations		
• Routine Eye Exam Copay: $40/visit Maximum of one routine exam per Participant per Calendar Year.	100% after you pay the Copay	60% after you meet the Annual Non-Network Deductible
• Non-routine or follow-up visits Copay: $40/visit	100% after you pay the Copay	60% after you meet the Annual Non-Network Deductible

[1]It is recommended that your Provider submit an RCR request to BCBSTX to confirm coverage, limitations, and Medical Necessity prior to rendering certain Covered Health Services. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity. In general, your Network PCP and other Network Providers are responsible for ensuring services they provide meet Medical Necessity criteria. When you choose to receive certain Covered Health Services from a Non-Network Provider, you are responsible for ensuring services will be covered under the Plan. This includes confirming Medical Necessity criteria are met. In the event a pre-service RCR or a post-service clinical review determines the service is not covered, you have the right to file an appeal as described in Section 8, *Claims Procedures* under the heading *Claim Denials and Appeals*.

*In general, a Non-Network Allowable Amount is less than a Network Allowable Amount. This means the Plan will usually pay less towards Non-Network Covered Health Services than Network Covered Health Services. As a result, when you receive Covered Health Services from a Non-Network Provider, your cost is generally higher. You may be responsible for the amount exceeding the Plan's Allowable Amount, which can be significantly more than when you receive Covered Health Services from a Network Provider. This is referred to as Balance Billing. For example, this may apply if you receive Covered Health Services at a Network Facility from a Non-Network Provider. You may not be responsible for an amount that exceeds your Participant responsibility for Deductibles, Copayments, and Coinsurance as part of the Plan's Allowable Amount for services provided by a Non-Network Facility-based Provider if performed at a Network Facility or Non-Network laboratory or diagnostic imaging services in connection with care delivered by a Network Provider unless the Non-Network Provider obtained your written acceptance of financial liability in advance. See, Section 3, *How the Plan Works,* under the heading *Accessing Benefits* for further information.

SECTION 6 - DETAILS FOR COVERED HEALTH SERVICES

What this section includes

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services recommended for pre-service clinical review.

This section supplements Table 3 in Section 5, *Schedule of Benefits and Coverage*.

Table 3 provides you with the percentage of Allowable Amount payable by the Plan, along with Benefit limitations, Copay and Annual Non-Network Deductible information for each Covered Health Service. This section provides more details about Covered Health Services and the Benefits for those services. These details provide any additional limitations that may apply and, identify the Covered Health Services for which it is recommended that your Provider obtain pre-service clinical review from BCBSTX. The Covered Health Services in this section appear in the same order as they do in Table 3 for easy reference. Health care services that are not covered are described in Section 7, *Exclusions: What the Medical Plan Will Not Cover*.

Reminders

All Covered Health Services must be determined by the Plan to be Medically Necessary.

Capitalized terms are defined in Section 13, *Glossary*, and may help you to understand the Benefits in this section.

Acquired Brain Injury

The Plan pays Benefits for the treatment of conditions that are the result of, and related to, acquired brain injury. Covered Health Services include, but are not limited to:

- cognitive rehabilitation therapy;
- cognitive communication therapy;
- community reintegration services;
- neurocognitive therapy and rehabilitation;
- neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment;
- neurofeedback therapy;
- post-acute transition services; and
- remediation.

Allergy Treatment

The Plan pays for Benefits for allergy treatment, including injections, testing and antigens/serum, received in a Physician's office or other Outpatient Facility when no other health service is received.

Ambulance Services

The Plan covers emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Services. See Section 13, *Glossary*, for the definition of Emergency Services.

Ambulance service by air is covered in an emergency if ground transportation is impossible or would seriously jeopardize your life or health. If special circumstances exist, the Plan may pay Network Benefits for emergency air transportation to a Hospital that is not the closest Facility to provide Emergency Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as the Plan determines appropriate) between Facilities when the transport is requested by a Physician and is:

- from a Non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of Medically Necessary care that was not available at the original Hospital;
- when the nearest appropriate Hospital is not accepting patients, has no available beds, has no accepting physicians or when the air ambulance cannot land;
- to a more Cost-Effective acute care Facility; or
- from an acute Facility to a sub-acute setting.

Prior authorization is no longer required for non-emergency ambulance transport. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Bariatric Surgery

Bariatric Surgery is the surgical treatment of obesity provided by or under the direction of a Physician. The Plan covers Bariatric Surgery provided that all of the following are true:

- you are an active Employee or former Employee enrolled in COBRA at the date of service, with three continuous years of GBP employment with no breaks in GBP coverage (Benefits for Bariatric Surgery are not available to Dependents or Retirees, including a Subscriber who is covered as a Dependent instead of a Subscriber under the Plan.); and
- you have medical records documenting that you have a Body Mass Index (BMI) of 40 or greater; or
- you have a BMI of 35-39 and one or more conditions considered to be a co-morbidity, uncontrolled even at maximum medical management, and which is generally expected to be reversed or improved by bariatric treatment. Co-morbidities include, but are not limited to:
    - type 2 diabetes;
    - cardiovascular disease (e.g., stroke, myocardial infarction, stable or unstable angina pectoris, hypertension or coronary artery bypass); and
    - life-threatening cardiopulmonary problems (e.g., severe sleep apnea, Pickwickian syndrome, obesity-related cardiomyopathy).

In addition to meeting the above criteria, the following must also be true:

- you have documented active participation in a comprehensive, non-surgical weight reduction program for at least 3 consecutive months during the 24-month period before the date of your Bariatric Surgery;
- you have been evaluated by a licensed professional counselor, psychologist, or psychiatrist at least once within the 12 months before the date of your Bariatric Surgery; and
- the surgery will be performed at a Blue Distinction Center by a Network surgeon even if there are no Blue Distinction Centers near you.

Benefits are available for Bariatric Surgery services that meet the definition of a Covered Health Service, as defined in Section 13, *Glossary*, and that are not considered Experimental or Investigational or Unproven Services. Surgery for a Body Mass Index (BMI) of 34 or less, even with one or more comorbidities, is considered not Medically Necessary.

Benefits are limited to $13,000 and one Bariatric Surgery per lifetime unless there are complications directly resulting from Bariatric Surgery that was covered and paid for by the Plan. The plan may cover reasonable and necessary medical or hospital services after a patient is discharged from a hospital stay for non-covered services, and then needs services to treat a condition or complication that resulted from the non-covered services. The plan does not pay for subsequent services normally incorporated into a global fee. A separate Bariatric Deductible applies to this Benefit. See Section 3, *How the Plan Works*, for details about this deductible.

Note: Allowable Amounts for Bariatric Surgery do not apply to the Out-of-Pocket Coinsurance Maximum or to the Total Out-of-Pocket Maximum. Even if these Out-of-Pocket Maximums are met, Allowable Amounts for Bariatric Surgery will not be paid at 100%. The Copays and Coinsurance shown in Table 3 in Section 5, *Schedule of Benefits and Coverage*, will continue to apply.

Note: The Bariatric Surgery period is one month before and 12 months following the date of the surgery. Covered Health Services provided by a Physician or other covered health care Provider are allowed under this Benefit for up to 12 months after the date of surgery.

You will have access to certain Blue Distinction Centers, as defined in Section 13, *Glossary*, for Bariatric Surgery services.

There is no coverage for Bariatric Surgery that fails to meet all Plan requirements as described in this Bariatric Surgery section or that is not performed by a Network Provider at a Blue Distinction Center.

Prior authorization is no longer required for Bariatric Surgery. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services**. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Chiropractic Treatment

The Plan provides Benefits for Chiropractic Treatment when provided by a licensed Doctor of Chiropractic.

For chiropractic services, other than maintenance or preventive Chiropractic Treatment, your chiropractor will be required to submit a treatment plan that outlines goal-directed rehabilitation services. Benefits can be denied or limited for Participants who are not progressing in goal-directed Chiropractic Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance or preventive Chiropractic Treatment.

Benefits for Chiropractic Treatment are limited to $75 per visit, regardless of whether the Provider is Network or Non-Network. Any combination of Network Benefits and Non-Network Benefits for Chiropractic Treatment is limited to 30 visits per Calendar Year.

If you receive Chiropractic Treatment from Airrosti Rehab Centers, you will have a $25 Copay per visit. The maximum Benefit of $75 per visit will not apply to Airrosti Rehab Center Providers. However, the 30 visit Benefit maximum will still apply.

Note
Airrosti Providers are not able to treat Participants with Medicare coverage (regardless of if Medicare is your Primary or Secondary Plan). If you have Medicare and are seeking additional treatment options, talk to your PCP about other potential treatment, or call a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711) for help locating other Network Providers.

Clinical Trials

Benefits for Routine Patient Care Costs incurred during participation in a qualifying Phase I, II, III or IV Clinical Trial for the prevention, detection or treatment of a life-threatening disease or condition. Benefits are provided for the reasonable and necessary items and services used to prevent, detect and treat complications arising from participation in a qualifying Clinical Trial. Benefits are available only when the Participant is clinically eligible for participation in the Clinical Trial as defined by the researcher.

Benefits for Routine Patient Care Costs for Clinical Trials include, but are not limited to:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

The following are not considered Routine Patient Care Costs for Clinical Trials and no Benefits are payable:

- the Experimental or Investigational Service or item;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- items and services associated with managing the Clinical Trial;
- items and services that are inconsistent with widely accepted and established standards of care for the particular diagnosis;

- any item or service that is not a Covered Health Service or is specifically excluded under the Plan, regardless of whether the item or service is required in connection with participation in a Clinical Trial; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

A qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV Clinical Trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is described in any of the following bullet points:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - National Institutes of Health (NIH), including the National Cancer Institute (NCI) (including a cancer center that has been designated by the NCI as a Clinical Cancer Center or Comprehensive Cancer Center);
    - Centers for Disease Control and Prevention (CDC);
    - Agency for Healthcare Research and Quality (AHRQ);
    - Centers for Medicare and Medicaid Services (CMS);
    - a cooperative group or center of any of the entities described above, the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
    - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
    - the Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to both:
        - be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        - assure unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or
    - an institutional review board of an institution in Texas that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services;
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before Participants are enrolled in the trial. The Plan may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Congenital Heart Disease (CHD) Services

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician. Benefits include, but are not limited to, the Facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- evaluation;
- fetal echocardiograms;
- interventional cardiac catheterizations;
- in-utero surgery to correct CHD or heart defects;
- Outpatient diagnostic testing; and
- surgical interventions.

CHD services other than those listed above are excluded from coverage, unless determined by BCBSTX to be proven procedures for the involved diagnoses. Contact BCBSTX at (800) 252-8039 (TTY: 711) for information about CHD services.

If you receive Congenital Heart Disease (CHD) services, the Plan pays Benefits as described under:

- *Hospital or other Facility – Inpatient Stay;*
- *Physician's Office Services - Sickness and Injury;*
- *Physician Fees for Covered Services;*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic;*
- *Surgery – Outpatient;* and
- *Therapeutic Treatments – Outpatient.*

Participants also have access to the Hello Heart program which focuses on your cardiovascular health, aiming to prevent or decrease the progression of heart disease and other related health conditions. For more information see *Addendum – Resources to Help You Stay Healthy*.

Prior authorization is no longer required for an Inpatient Stay. However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Dental Services

Accident-Related

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage caused by physical trauma, including but not limited to, such Injury resulting from domestic violence or a medical condition, to sound and natural teeth (i.e., teeth with no major restorations and no periodontal involvement) and/or dental work that was in place at the time of the Injury, including, but not limited to, crowns, veneers, bridges and implants;
- the dental damage did not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are performed by a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and

- the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the dental damage and if extenuating circumstances exist due to the severity of the accident that caused the dental damage).

Dental services for final treatment to repair the accidental dental damage must be completed within 24 months of the accident.

The Plan provides Benefits for only the following treatment of accidental dental damage:

- emergency examination;
- endodontic (root canal) treatment;
- extractions;
- necessary diagnostic X-rays;
- post-traumatic crowns if such are the only clinically acceptable treatment;
- prefabricated post and core;
- replacement of lost teeth due to the Injury;
- restoration or replacement of dental work that was in place at the time of the Injury, including, but not limited to, crowns, veneers, bridges and implants;
- simple minimal restorative procedures (fillings);
- temporary repairs immediately following the Injury that will allow any of the above permanent repairs to be performed; and
- temporary splinting of teeth.

Alternate Benefit for Accident-Related Dental Services

If you require new dental work, such as crowns or implants, or repair/replacement of dental work that was in place at the time of the Injury, as described above, the Plan will pay Benefits for the most Cost-Effective procedure(s) recommended by the treating Provider. However, if you choose to have a more costly procedure(s), the Plan may reimburse you for a portion of your costs, up to a maximum of the amount of the more Cost-Effective procedure. When you submit your claim, you must include an estimate from the Provider for the more Cost-Effective procedure(s) in addition to receipts for the alternate procedure(s) actually performed. You will receive a maximum reimbursement of the amount estimated for the more Cost-Effective procedure(s).

Medical Condition-Related

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system);
- treatment or correction of a Congenital Anomaly when provided to an eligible Dependent child; and
- direct treatment of cancer or cleft palate.

The Plan also provides Benefits for Covered Health Services for oral surgery for the following:

- excision of neoplasms, including benign, malignant and premalignant lesions, tumors and non-odontogenic cysts;
- incision and drainage of cellulitis;
- surgical procedures involving sinuses, salivary glands and ducts;
- removal of teeth if integral to a medical procedure prior to radiation therapy of the head and neck, but not the dental reconstruction for the replacement of the extracted teeth;
- replacement of natural teeth lost as a result of radiation therapy performed while you are a Participant in the Plan;
- reconstruction after tumor removal (including bone grafting and dental implants if necessary to stabilize a maxillofacial prosthesis such as an obturator); and
- removal of broken teeth if necessary to reduce jaw fracture.

Dental Anesthesia

The Plan provides Benefits for dental anesthesia for a Participant whose dentist provides documentation that states he or she cannot undergo local anesthesia because of a documented physical, mental or medical reason.

Charges for the dental procedure itself, including, but not limited to, the professional fees of the dentist, are not covered.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetic Eye Examinations/Foot Care	Benefits under this section include, but are not limited to, medical eye examinations (dilated retinal examinations) and routine or Medically Necessary foot care for Participants with diabetes.
Diabetes Self-Management Training Programs	Benefits are provided for Outpatient self-management training, including, but not limited to: • training after the initial diagnosis of diabetes regarding the care and management of diabetes, nutritional counseling and proper use of diabetes equipment and supplies; • training after a significant diagnosed change in symptoms or condition requiring change in self-management regime; and • periodic training warranted by the development of new techniques and treatment for diabetes. These services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Covered Diabetes Services	
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Participant as described below. Covered diabetes equipment is specifically defined as: • continuous glucose monitors, including monitors designed to be used by blind individuals (Note: Certain continuous glucose monitors are available through the HealthSelect of Texas Prescription Drug Program (PDP) and often at a lower cost); • insulin infusion devices; • insulin pumps and associated appurtenances; • diabetic supplies used exclusively with a Provider-prescribed insulin pump or continuous glucose monitor; and • podiatric appliances (shoes, shoe inserts and foot orthotics) for the prevention of complications associated with diabetes. Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section. ***Note:*** Certain diabetic supplies including, but not limited to: glucometers, test strips, lancets and lancing devices, alcohol swabs and wipes, are covered with a Copay through pharmacy benefits under the HealthSelect of Texas Prescription Drug Program (PDP). The Free Glucose Meter Program available through the PDP allows Participants to receive a free glucometer annually with test strips at no cost when filled at a Network pharmacy**. Diabetic supplies are not available through the HealthSelect of Texas medical plan.**

To receive Network Benefits for Diabetic DME, you must purchase or rent the DME from a Network Provider. Your Provider must prescribe the Medically Necessary equipment or supply.

Covered diabetes equipment can be purchased from either a Network Provider or Non-Network Provider (or retail location), at the Network Benefit level. If you purchase your covered diabetes equipment from a Non-Network Provider or retail location, you may have to file a claim for reimbursement.

Important: Diabetic supplies are not available under this plan (except for the covered diabetes equipment listed above). Diabetic supplies are available through the pharmacy benefit with the HealthSelect of Texas Prescription Drug Program (PDP). For details about diabetic supply coverage under the HealthSelect Prescription Drug Program, go to **healthselectrx.com**.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for Outpatient use;
- not consumable or disposable;
- used for medical purposes with respect to treatment of a Sickness, Injury or disability or their symptoms;

- durable enough to withstand repeated use;
- not implantable within the body (except as noted below); and
- appropriate for use, and primarily used, within the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include, but are not limited to:

- continuous positive airway pressure device (CPAP or BIPAP);
- equipment to administer oxygen (e.g., respirator);
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (e.g., wound vacuums);
- burn garments;
- insulin pumps and all related insulin pump supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. (***Note:*** Cochlear implants are also covered by the Plan under *Hospital or Other Facility - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* or *Surgery - Outpatient* in this section);
- cranial remolding orthotics (e.g., cranial helmets);
- braces that stabilize an injured body part, including, but not limited to, necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers batteries, tubing, nasal cannulas, connectors, headgear, and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three Calendar Years.

At the Plan's discretion, replacements may be covered when the DME is damaged beyond repair due to normal wear and tear, when repair costs exceed new purchase price or when a replacement piece of DME is required due to the Participant’s growth or other physical change or a change in the Participant’s abilities or condition occurs sooner than the three-year timeframe. Repairs, including, but not limited to, the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.

To receive Network Benefits, you must purchase or rent DME from a Network Provider. Your Provider must prescribe the Medically Necessary equipment or supply.

Emergency Room Services - Outpatient

The Plan's emergency room services Benefit pays for Outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an Inpatient to a Hospital directly from the emergency room, you will not have to pay the Copay for emergency room services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an emergency admission for a Non-Network Hospital or other Facility stay as long as BCBSTX is notified within 48 hours, or the next business day, after you are admitted to a Non-Network Hospital or other Facility. If you continue your stay in a Non-Network Hospital or other Facility after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital or other Facility, Non-Network Benefits will apply.

For more information regarding your Emergency Room Services by Non-Network Providers, see *Addendum – Your Rights and Protections Against Surprise Medical Bills under the No Surprises Act and Texas Law.*

Emergency room Benefits may be available when you seek such services to evaluate and stabilize conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the unborn child;

However, you may receive Non-Network Benefits if you receive services at a Non-Network Hospital or Other Facility that are not billed by the Provider or Facility as an emergency.

A Freestanding Emergency Room and Freestanding Emergency Department are care Facilities that are structurally separate and distinct from a Hospital that provides Emergency Services.

When you use a Network Provider, the Network Provider is responsible for contacting BCBSTX within 48 hours, or the next business day, after you are admitted to a Network Hospital or other Facility as a result of an emergency.

Prior authorization is no longer required for an Inpatient Stay. **However, it is recommended that your Provider submit an RCR request to BCBSTX to confirm coverage, limitations, and Medical Necessity within 48 hours if you are admitted to the Hospital following an Emergency Room visit.** If your Provider chooses not to request RCR within 48 hours of admission, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Family Planning and Infertility Services

The Plan pays Benefits for most family planning services and supplies. Coverage is provided for contraceptive counseling, elective sterilization procedures (tubal ligation or vasectomy), contraceptives drugs administered by a Provider (e.g., Depo-Provera, Norplant) and contraceptive devices (e.g., diaphragm, intrauterine device (IUD)), including fitting and removal.

Note: Oral contraceptives are covered under the HealthSelect Prescription Drug Program (PDP).

Infertility Benefits are only for diagnostic laboratory and X-ray procedures, therapeutic injections and surgical treatment necessary for the diagnosis and treatment of involuntary infertility (i.e., infertility that is not a result of voluntary sterilization).

For services specifically excluded, refer to Section 7, *Exclusions: What the Medical Plan Will Not Cover*, under the heading *Reproduction/Infertility*.

Habilitation and Rehabilitation Services - Outpatient Therapy

The Plan provides short-term Outpatient Habilitation and rehabilitation services for the following types of therapy:

- Applied Behavioral Analysis (ABA), for Autism Spectrum Disorders only;
- cardiac rehabilitation;
- cognitive rehabilitation therapy following a traumatic brain Injury or cerebral vascular accident;
- occupational therapy;
- physical therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- speech therapy.

Benefits provided under this section include “Habilitation” services, which are health care services that help a person keep, learn or improve skills and functioning for daily living prescribed by a Participant’s treating Physician pursuant to a treatment plan to develop a function not previously developed as a result of a disabling condition, or a disorder resulting from Sickness, Injury, trauma or other event or condition suffered by the Participant prior to the development by that Participant of one or more functional life skills such as walking or talking. Benefits for Habilitation services do not apply to Educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Habilitation services.

To be Covered Health Services, all Habilitation services or rehabilitation services must be performed by a licensed therapy Provider under the direction of a Physician (when required by state law) and must be provided in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility. Your Provider will be required to submit a treatment plan that outlines goal-directed Habilitation services or rehabilitation services. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of Habilitation services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

Massage therapy is a Covered Health Service when Medically Necessary and provided by a licensed therapy Provider, subject to all the conditions of this section.

Except as described below under *Therapies for Children with Developmental Delay Services*, the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when:

- the speech impediment or dysfunction results from a Congenital Anomaly or Injury or Sickness, including, but not limited to, stroke, cancer or Autism Spectrum Disorder;
- needed following the placement of a cochlear implant; or
- used to treat stuttering, stammering, or other articulation disorders not related to an underlying condition.

Participants also have access to Hinge Health, a digital, physical therapist (PT)-led musculoskeletal (MSK) care program. For more information, see *Addendum – Resources to Help You Stay Healthy*.

Hearing Aids

The Plan pays Benefits for hearing aids requiring a Prescription that are for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a prescription written by a Physician or licensed Audiologist. Benefits are provided for the hearing aid and for charges associated with fitting and testing.

Please note: A valid prescription must be filed with all hearing aid claims to receive benefits.

Any combination of Network Benefits and Non-Network Benefits for hearing aids requiring a prescription, including fitting, testing and molds, are limited to $1,000 per hearing impaired ear for any consecutive 36-month period. Eligible Participants 18 years of age and younger are not subject to the $1,000 Benefit limit for hearing aids. Eligible Participants 18 years of age and younger may also receive coverage for one cochlear implant per ear with internal replacement as Medically Necessary.

Replacement of an existing, functioning cochlear implant external component is covered only when a physician certifies that:

- The existing component is ineffective to the point of interfering with the activities of daily living, or
- When there is a change in the patient's condition necessitating a different type of component, or
- The existing component has reached its reasonable useful life. The reasonable useful life of a sound processor is not less than 5 years.

Hearing aid batteries are not included in the hearing aid Benefit limit. Hearing aid batteries for the hearing aid requiring a prescription are covered at 100% up to maximum of $1 per battery. You must submit a receipt with a completed claim form located under the *Publications and Forms* section at **healthselectoftexas.com**.

Benefits do not include dispensing fees, except for those Participants 18 years of age and younger, or repairs to a hearing aid, even if the hearing aid purchase was a Covered Health Service under the Plan.

Note: Limited coverage of bone anchored hearing aids is provided as described under *Prosthetic Devices* in this section.

High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

The Plan pays Benefits for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include, but are not limited to:

- the Facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits for other Physician services are described in this section under *Physician Fees for Covered Services*.

Prior authorization is no longer required for High Tech Radiology. However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.), or provided by either a home health aide or licensed practical nurse (L.P.N.) and supervised by a registered nurse, in your home;
- not considered Custodial Care, as defined in Section 13, *Glossary*; and
- provided on a part-time or Intermittent Skilled Nursing Care schedule when Skilled Care is required. Refer to Section 13, *Glossary*, for the definition of Skilled Care.

BCBSTX will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be Skilled Care simply because there is not an available caregiver.

Covered Health Services for home health care include, but are not limited to:

- physical, occupational (when consisting of traditional physical therapy modalities), speech and respiratory therapy services provided by a licensed therapist; and
- supplies and equipment routinely provided by a Home Health Agency.

For services specifically excluded, refer to Section 7, *Exclusions: What the Medical Plan Will Not Cover*, under the heading *Types of Care*.

Benefits under this section are provided for home infusion therapy, which is the administration of fluids, nutrition or medication (including, but not limited to, all additives, and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. There is no coverage for home infusion therapy unless it is performed by a Network Provider.

Home infusion therapy includes, but is not limited to:

- drug and intravenous solutions;
- pharmacy compounding and dispensing services;
- all equipment and ancillary supplies necessitated by the defined therapy;
- delivery services;
- patient and family education; and
- nursing services.

Non-Network Benefits for home health care are limited to 100 visits per Calendar Year. One visit equals four hours of Skilled Care services. Home health care visits from both Network and Non-Network Providers apply to this limit.

Prior authorization is no longer required for Home Health Care. However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill Participant. Hospice care can be provided on an Inpatient or Outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill Participant and short-term grief (bereavement) counseling for immediate family members while the Participant is receiving Hospice care. Benefits are available only when Hospice care is received from a licensed Hospice, which can include a Hospital or other Facility.

Benefits for Outpatient Hospice care include, but are not limited to:

- part-time or intermittent nursing care by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.); and
- part-time or intermittent home health aide services that consist primarily of caring for the Participant.

Benefits for Inpatient Hospice care include, but are not limited to:

- all usual nursing care by a registered nurse (R.N.) or licensed vocational nurse (L.V.N.); and
- room and board and all routine services, supplies and equipment provided by the Hospice Facility.

Benefits for Inpatient or Outpatient Hospice care include, but are not limited to:

- physical, occupational (when consisting of traditional physical therapy modalities), speech, and respiratory therapy services provided by a licensed therapist; and
- counseling services by licensed social workers and pastoral counselors routinely provided by the Hospice agency, including bereavement counseling.

For services specifically excluded, refer to Section 7, *Exclusions: What the Medical Plan Will Not Cover*, under the heading *Types of Care*.

Prior authorization is no longer required for an Inpatient Hospice**. However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Hospital or Other Facility - Inpatient Stay

Hospital or other Facility - Inpatient Stay Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room; and
- services under a Provider's scope of license.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

Benefits for a Hospital or other Facility - Inpatient Stay are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Facility-based Physician services provided in a Hospital are described in this section under *Physician Fees for Covered Services*.

If you are discharged and then readmitted to the Hospital or other Facility within 24 hours for the same condition, the Copays you paid for the initial admission are combined with the Copay(s) for the readmission to reach the per-admission maximum.

Example
You are admitted to the Hospital or other Facility and have an Inpatient Stay of three days, paying a Copay of $450 ($150 per day for three days). You are discharged at 5 p.m. on the third day and then readmitted at 8:30 a.m. the following morning for the same condition and have an Inpatient Stay of four days. You will pay an additional Copay of $300 ($150 per day for two days), because that amount is combined with the $450 Copay to reach the per-admission maximum of $750.

Benefits for emergency admissions and admissions of less than 24 hours are described under *Emergency Room Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively, in this section.

For more information about ProgenyHealth support for Neonatal Intensive Care Unit (NICU) admissions see *Addendum – Resources to Help You Stay Healthy.*

Prior authorization is no longer required for an Inpatient Stay. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Please note*:* Even with Inpatient Benefits applied, you could pay more of the cost when using a Non-Network Provider at a Network Inpatient Facility.

Lab, X-Ray and Diagnostics - Outpatient

Covered Health Services for Sickness and Injury-related diagnostic purposes, received on an Outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- lab and radiology/X-ray;
- mammography, including digital breast tomosynthesis/3D mammography, ultrasound imaging or magnetic resonance imaging (MRI); and
- bone density screening.

Benefits under this section include, but are not limited to:

- the Facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Covered Services*. Lab, X-ray and other services for Preventive Care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Diagnostic mammograms are covered at 100% of the Allowable Amount when the service is provided by a Network Provider. You could pay more of the cost when using a Non-Network Provider.

Prior authorization is no longer required for a sleep study. However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, Recommended Clinical Review (RCR).

Maternity Care

The Plan provides Benefits for Covered Health Services related to Pregnancy and maternity care. Covered Health Services include, but are not limited to, all maternity-related medical services for prenatal care, postnatal care, delivery services provided by the delivering Physician or Midwife (a Midwife must be a Certified Nurse Midwife licensed as an Advanced Practice Nurse (APN or APRN)), laboratory tests, sonograms, stress tests, amniocentesis and expenses for the Hospital or other Facility Inpatient Stay, including assistant surgeon or anesthesiologist fees if required. Benefits to treat any related Complications of Pregnancy will be paid at the same level as Benefits for any other condition, Sickness, or Injury.

A Copay will be required for the initial Network Provider office visit for maternity care but will not be required for subsequent maternity care visits. Dependent children will be eligible for maternity care Benefits.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn following an uncomplicated vaginal delivery; or
- 96 hours for the mother and newborn following an uncomplicated delivery by caesarean section.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for Post-Delivery Care for the mother and newborn. The Post-Delivery Care may be provided at the mother's home, a health care Provider's office, or a health care Facility.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Participants in the immediate family. Covered Health Services include related tests and treatment.

Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother's Hospital admission for the delivery will be considered Hospital or other Facility – Inpatient Stay expenses of the child and will be subject to the benefit provisions and benefit maximums as described under *Hospital – Inpatient Stay* in this section.

For more information about ProgenyHealth support for Neonatal Intensive Care Unit (NICU) admissions see *Addendum – Resources to Help You Stay Healthy.*

Prior authorization is no longer required for an Inpatient Stay. However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity if the mother and/or the newborn will remain hospitalized longer than the timeframe indicated above. If your Provider chooses not to request RCR, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Medical Supplies

The Plan pays Benefits for medical or disposable supplies when the supplies are prescribed by a Physician. Covered Health Services include, but are not limited to:

- urinary catheters;
- wound care or dressing supplies given by a Provider during treatment for Covered Health Services; and
- medical-grade compression stockings when considered Medically Necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient.

Coverage also includes disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment and Diabetes Services* in this section.

Medications and Injections - Outpatient

The Plan pays for Medications and Injections that are administered on an Outpatient basis in a Hospital or other Facility, Alternate Facility or Physician's office. The Plan also pays for Medications and Injections that are administered in a Participant's home but only by a Network Provider. Examples of what would be included under this category are antibiotic injections in the Physician's office, inhaled medication in an Urgent Care Center for treatment of an asthma attack or Medically Necessary growth hormone therapy.

Benefits under this section are provided only for Medications and Injections that, due to their characteristics (as determined by BCBSTX), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional. If approved for self-administration by the United States Food and Drug Administration (FDA), the injection can be filled through the HealthSelect of Texas Prescription Drug Program (PDP).

Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy under the HealthSelect Prescription Drug Program (PDP). Additional information is located at **HealthSelectRx.com**.

Mental Health Services

The Plan pays Benefits for Mental Health Services for the treatment of Mental Illness received on an Inpatient or Outpatient basis in a Hospital or other Facility, an Alternate Facility, in a Provider's office, Telemedicine or with a Virtual Network Provider. Services must be received from a Mental Health Provider as defined in Section 13, *Glossary*.

Covered Health Services include, but are not limited to, the following services:

- crisis intervention;
- diagnostic evaluations and assessment;
- electroconvulsive treatment;
- individual, family, therapeutic group and Provider-based case management services;
- individual or group psychotherapy;
- Intensive Outpatient Program (IOP);
- medication management;
- mental health counseling;
- Partial Hospitalization Program (PHP)/Day Treatment;
- psychodynamic therapy;
- psychological testing and assessment;
- psychotropic drugs, including their administration;
- referral services;
- services at a Residential Treatment Center;
- treatment planning; and
- treatment and/or procedures.

Covered Health Services also include transcranial magnetic stimulation (TMS) provided on an Outpatient basis for an adult patient with a major depressive disorder that has not been responsive to other Medically Necessary treatments.

BCBSTX, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact BCBSTX for coordination of care. Contact a BCBSTX Personal Health Assistant (800) 252-8039 (TTY: 711) for assistance.

Participants have access to Learn to Live, an online, on-demand, self-paced mental health service, at no additional cost. For more information see *Addendum – Resources to Help You Stay Healthy*.

Prior authorization is no longer required for Inpatient services, Residential Treatment Facility, or Partial Hospitalization admissions. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Please note: Even with inpatient Benefits applied, you could pay more of the cost when using a Non-Network Provider at a Network inpatient Hospital or other Facility.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for Autism Spectrum Disorders including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are all of the following:

- focused on the treatment of core deficits of Autism Spectrum Disorder;
- provided by a Mental Health Provider who is a master's level clinician licensed, certified, or registered by an appropriate agency in the state where services are being provided for services treating Autism Spectrum Disorder symptoms, or by a master's level clinician with an appropriate state license who is a Board-Certified Behavior Analyst (BCBA), or by an appropriately trained and qualified paraprofessional directly supervised by the BCBA;
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impair daily functioning; and
- backed by credible peer-reviewed research demonstrating that the services have a measurable and beneficial effect on health outcomes.

These Covered Health Services include only the behavioral component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical *Covered Health Services* categories as described in this section and subject to the terms and limitations of the Plan.

Covered Health Services include, but are not limited to, the following services provided on either an Outpatient or Inpatient basis:

- crisis intervention;
- diagnostic evaluations and assessment;
- individual, family, therapeutic group and Provider-based case management services;
- Intensive Outpatient Program (IOP);
- medication management;

- Partial Hospitalization Program (PHP)/Day Treatment;
- referral services;
- services at a Residential Treatment Facility; and
- treatment planning.

BCBSTX, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact BCBSTX for coordination of care. Inpatient Mental Health Services for Autism Spectrum Disorders must be authorized and overseen by BCBSTX. In addition, BCSTX will authorize and oversee Benefits for Intensive Behavioral Therapy.

Clinical Management: BCBSTX will perform clinical management of these Benefits. Clinical management includes Provider eligibility verification. In addition, an Autism specialist will review detailed treatment plans from the treating Provider for both initial and ongoing treatment. At a minimum, treatment plans are reviewed every six months by the Autism specialist for progress and appropriateness of care.

Prior authorization is no longer required for scheduled Inpatient services, Residential Treatment Facility, Partial Hospitalization admissions, Applied Behavioral Analysis (ABA), and certain Outpatient services. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4*, Recommended Clinical Review (RCR)*.

Please note: Even with inpatient Benefits applied, you could pay more of the cost when using a Non-Network Provider at a Network inpatient Facility.

Nutritional Counseling

The Plan pays Benefits for medical education services provided in a Physician's office or Inpatient setting by an appropriately licensed or health care professional when:

- medical education services are required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such conditions include, but are not limited to:

- congestive heart failure;
- coronary artery disease;
- diabetes;
- gout (a form of arthritis);
- hyperlipidemia (excess of fatty substances in the blood);
- phenylketonuria (a genetic disorder diagnosed at infancy);
- renal failure; and

- severe obstructive airway disease.

Nutritional counseling services include, but are not limited to, the education, counseling, or training of a Participant regarding diet, regulation or management of diet or the assessment or management of nutrition.

In addition, the Plan provides Benefits for dietary or nutritional evaluations for Participants with Developmental Delay that are determined to be necessary to, and provided in accordance with, an Individualized Family Service Plan issued by the Interagency Council on Early Childhood Intervention.

Ostomy Supplies

Benefits for ostomy supplies include, but are not limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters;
- skin barriers; and
- deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover.

Physician Fees for Covered Services

The Plan pays Benefits for Physician fees for surgical procedures and other care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Benefits under this section include Second Opinions from Physicians related to Medical Necessary Covered Health Services and surgical procedures or other care as described above.

Physician's Office Services - Sickness and Injury

The Plan pays Benefits for Covered Health Services received in a Physician's office for the evaluation, diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital or other Facility, or is an Outpatient Clinic Facility. Benefits under this section include, but are not limited to, allergy injections and hearing exams in case of Injury or Sickness.

Benefits under this section include Second Opinions from Physicians related to Medically Necessary Covered Health Services and procedures provided in a Physician’s office.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing determined to be Medically Necessary following genetic counseling when ordered by the Physician.

Covered Health Services also include Telemedicine services, such as the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits for high-tech radiology such as CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services performed in the Physician's office are described under *High-Tech Radiology - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Participants also have access to the Hello Heart program which focuses on your cardiovascular health, aiming to prevent or decrease the progression of heart disease and other related health conditions. For more information see *Addendum – Resources to Help You Stay Healthy*.

Prior authorization is no longer required for Genetic Testing, such as BRCA (breast cancer gene). However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Please Note:
Your Physician does not have a copy of your MBPD and is not responsible for knowing or communicating your Benefits.

Preventive Care Services

The Plan pays Benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital. To be considered Preventive Care, Covered Health Services, services must be received from a Network Provider and/or Facility. Preventive Care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- immunizations that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);
- with respect to infants, children and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration (HRSA); and
- with respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the federal HRSA. *Preventive Care Services* described in this section are those that are relevant for implementing the Affordable Care Act to the extent required by applicable law, and as it may be amended, and subject to determination and interpretation by the Plan.

Diagnostic mammography is covered at 100% of the Allowable Amount when received by a Network Provider. You could pay more of the cost when using a Non-Network Provider.

Preventive Services that are currently rated as A or B according to the United States Preventive Services Task Force (USPSTF), or as recommended by the CDC or HRSA, are listed in *Addendum - List of Covered Preventive Care Services*. This list is subject to change according to the guidelines and recommendation provided by USPSTF, CDC, or HRSA, as determined by the Plan. Coverage is subject to guidelines based on age, dosage, and frequency.

The VirtualCheckup® by Catapult Health gives eligible HealthSelect medical plan Participants the opportunity to receive a virtual preventive checkup with a nurse practitioner at no cost. For more information see *Addendum - Resources to Help You Stay Healthy*.

Please Note:
If the Preventive Care guidelines include an annual limit, the limit will apply on a Calendar Year basis.

Breastfeeding Support, Services and Supplies

The Plan provides Benefits for lactation support and counseling sessions to female Participants in conjunction with childbirth. To be considered Preventive Care, Covered Health Services, services must be received from a Network Provider and/or Facility.

Benefits are provided for breastfeeding consultation, counseling, education by clinicians and peer support services when rendered by a Provider, during Pregnancy and/or in the post-partum period. Benefits include the rental or the purchase of manual or electric breast pumps, accessories and supplies, including breast milk storage supplies. Benefits for breast pumps are limited to one per Pregnancy, or one per newly eligible newborn Dependent who is not a Participant's natural child. Limited Benefits are also included for the rental of Hospital grade breast pumps. You may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual electric or Hospital grade breast pump, accessories and supplies, including breast milk storage supplies. Visit **healthselectoftexas.com** to obtain a claim form.

Preventive Care Benefits defined under the federal HRSA requirement provide for the cost of purchasing one breast pump per Pregnancy or one per newly eligible newborn Dependent who is not a Participant's natural child. You may purchase a breast pump from a Network DME Provider or Physician. You may also purchase a breast pump at a retail location and submit a claim as described in Section 8, *Claims Procedures*. Benefits for breast pumps with a valid Prescription Order rented or purchased from an In-Network Provider or a retail location are provided at 100% of Allowable Amounts. For breast pumps purchased from a retail location, you must submit a claim form to BCBSTX for reimbursement.

If you use a Non-Network Provider, the Benefits may be subject to the Annual Non-Network Deductible, Coinsurance, Copay and/or Benefit maximum.

For more information, contact a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711).

The Plan pays Benefits only for a breast pump purchased 30 days or less before the newborn delivery date or newborn placement for adoption date. You or your Provider should provide the delivery date on the claim. Breast pumps are covered under the Plan as long as they are purchased within the duration of breastfeeding.

Note: Any shipping costs related to purchase of a breast pump are not Covered Health Services under this Benefit.

Private Duty Nursing - Outpatient

The Plan covers Private Duty Nursing care when ordered and provided under the direction of a Physician and given on an Outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

Benefits are available when Skilled Care is needed, and nursing intervention is required at least every two to three hours and when one or more of the following is true:

- the Participant's condition makes him or her homebound; or

- the Participant's condition plus the geographic distance make it unreasonable for him or her to obtain the needed services in an Outpatient Facility or Physician's office; or
- the Participant's condition makes him or her technology dependent;
- services are needed on a continuous basis (e.g., suctioning or hemodynamic monitoring) to assure immediate intervention if required; or
- the services are more Cost-Effective in the home than an alternative setting.

The Participant's treatment plan should be reviewed periodically (no less than every 60 days, or as determined by the Plan) and updated by the Physician.

Benefits are provided for the time devoted to providing the Participant with Medically Necessary services.

Non-Network Benefits are limited to 96 hours per Calendar Year.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 13, *Glossary*.

Prior authorization is no longer required for Private Duty Nursing. However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services. If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Prosthetic Devices

The Plan pays Benefits for prosthetic devices and appliances that replace a limb or body part or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are also provided for bone anchored hearing aids only for Participants who have either of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Note: Procedures related to covered bone anchored hearing aids are also covered by the Plan under *Hospital or Other Facility - Inpatient Stay* or *Surgery - Outpatient* in this section.

- Benefits under this section allow for coverage of cranial hair prosthesis (wig), limited to $1,000 per lifetime, for a Participant who experiences hair loss due to a side-effect of cancer treatment, chemotherapy, radiation, or the medical conditions of Alopecia or kidney-related hair loss.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

At the Plan's discretion, replacements may be covered when the prosthetic device is damaged beyond repair due to normal wear and tear, when repair costs are more than the cost of replacement or when a replacement prosthetic device is required due to the Participant's growth or other physical change or a change in the Participant's abilities or condition.

Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a condition or to improve or restore physiologic function for an organ or body part and not primarily change or improve the physical appearance of a healthy organ or body part. Reconstructive Procedures include surgery or other procedures that are associated with an Injury, Sickness or Congenital Anomaly.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including, but not limited to, breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact BCBSTX at (800) 252-8039 (TTY: 711) for more information about Benefits for mastectomy-related services.

When the purpose of a procedure is to improve the appearance of a healthy body part, it is a Cosmetic Procedure and excluded from coverage under the Plan. For Participants aged 19 and over, procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. An example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure, including but not limited to, a procedure or surgery to remove fatty tissue and/or hanging skin on any part of the body, even if hanging skin is due to weight loss, or to Bariatric Surgery otherwise covered under the Plan. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 13, *Glossary*.

A Participant may suffer negative psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly, but that does not qualify the surgery to address the condition (or other procedures done to relieve such consequences or behavior) as a covered Reconstructive Procedure.

For Participants under the age of 19, Reconstructive Procedures that improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by a Congenital Anomaly, development deformity, trauma, tumor, infection or disease are not considered Cosmetic Procedures and are Covered Health Services under the Plan.

Prior authorization is no longer required for a scheduled Reconstructive Procedure admission. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Please note: Even with Inpatient Benefits applied, you could pay more of the cost when using a Non-Network Provider at a Network Inpatient Facility.

Retail Health Clinic

The Plan pays Benefits for Covered Health Services provided in a Retail Health Clinic. Benefits for Retail Health Clinics will be determined as shown in Section 5, *Schedule of Benefits and Coverage*. Retail Health Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional Provider office visit or emergency care visit. Retail Health Clinics are often located in a retail setting such as a supermarket or pharmacy and may be staffed by Advanced Practice Nurses and Physician Assistants.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays Benefits for diagnostic and therapeutic scopic procedures and related services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are minimally invasive medical examinations that enable visualization, performance of biopsies and polyp removal. Examples of diagnostic scopic procedures include, but are not limited to, colonoscopy, sigmoidoscopy, and endoscopy. Therapeutic scopic procedures are usually surgical in nature. Examples of therapeutic scopic procedures include, but are not limited to, bronchoscopy and esophagoscopy.

Benefits under this section include, but are not limited to:

- the Facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Benefits for other Physician services are described in this section under *Physician Fees for Covered Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery – Outpatient*. Examples of surgical scopic procedures include, but are not limited to, arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Important Note Regarding Colonoscopies:
When stool-based or visualized tests reveal abnormal results, follow-up with a colonoscopy is needed for further evaluation and will be covered at $0 cost share the same as the initial Preventive Care screening, which includes required consultation prior to screening, anesthesiology and other services or items required for the procedure.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The Plan pays Facility services Benefits for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits include, but are not limited to:

- non-Physician services and supplies received during the Inpatient Stay;

- room and board in a Semi-private Room; and
- Physician services for radiologists, anesthesiologists and pathologists.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice. Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis.

Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital or other Facility.

Benefits for other Physician services are described in this section under *Physician Fees for Covered Services*.

The Plan will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative place of treatment, which could provide the appropriate level of care; and
- the Skilled Care services to be provided are not primarily Custodial Care.

Your Provider will be required to submit a treatment plan that outlines goal-directed rehabilitation services. Benefits can be denied or shortened for Participants who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 13, *Glossary*.

Prior authorization is no longer required for scheduled admissions. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Please note: Even with Inpatient Benefits applied, you could pay more of the cost when using a Non-Network Provider at a Network Inpatient Facility.

Substance Use Disorder Services

The Plan pays Benefits for Substance Use Disorder Services (also known as substance-related and addictive disorders services) received on an Inpatient or Outpatient basis in a Hospital or other Facility, an Alternate Facility or in a Provider's office.

Covered Health Services include, but are not limited to, the following services:

- crisis intervention;
- detoxification (sub-acute/non-medical);
- diagnostic evaluations and assessment;
- individual, family, therapeutic group and Provider-based case management services;
- Intensive Outpatient Program (IOP);

- medication management;
- Partial Hospitalization Program (PHP)/Day Treatment;
- referral services;
- services at a Residential Treatment Facility; and
- treatment planning.

BCBSTX, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Note: The Plan will pay the difference in cost between a Semi-private Room and a private room only when a Semi-private Room is not available or if a private room is Medically Necessary according to generally accepted medical practice.

You are encouraged to contact BCBSTX for coordination of care at (800) 252-8039 (TTY: 711). Inpatient Substance Use Disorder Services must be authorized and overseen by BCBSTX.

Prior authorization is no longer required for scheduled Inpatient services, or for Residential Treatment Facility or Partial Hospitalization admissions. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Please note: Even with Inpatient Benefits applied, you could pay more of the cost when using a Non-Network Provider at a Network Inpatient Facility.

Surgery - Outpatient

The Plan provides Benefits for surgery and related services received on an Outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Covered Health Services under this section include, but are not limited to:

- surgery and related services;
- the Facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

Examples of surgical procedures performed in a Physician's office include, but are not limited to, mole removal and ear wax removal.

Prior authorization is no longer required for Outpatient Surgery. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Telemedicine

The Plan covers Telemedicine visits with your Primary Care Provider, Mental Health Provider and other Specialists for Covered Health Services.

Telemedicine is when certain Covered Health Services are provided by your Primary Care Provider, Mental Health Provider, and other Specialists through use of a provider-platform that may include interactive audio, video, other electronic media or advanced telecommunications technology.

Your Primary Care Provider, Mental Health Provider, and other Specialists may be able to provide many of the services you would normally have in a face-to-face visit via a Telemedicine visit. Contact your Provider(s) to find out if they are offering this convenient option for care, if a Telemedicine visit is appropriate for your care, and how to schedule a Telemedicine visit.

Telemedicine visits are covered the same as in-person Primary Care Provider, Mental Health Provider, and other Specialist services, visits, or consultations as listed in Section 5, *Schedule of Benefits and Coverage*.

Telemedicine services are different than Virtual Visits. See *Virtual Visits* in this section for more information on what a Virtual Visits is and when a Virtual Visit may be appropriate.

If you have questions or need assistance locating a Network Provider, contact a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711).

Temporomandibular Joint (TMJ) Services and Orthognathic Surgery

The plan pays for the initial diagnosis and surgical treatment of temporomandibular joint dysfunction (TMJ) when provided by or under the direction of a Physician.

Coverage includes, but is not limited to, necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology.

Covered diagnostic treatment includes, but is not limited to, examination, radiographs and applicable imaging studies and consultation.

Benefits are provided for TMJ surgical treatment if:

- there is clearly demonstrated radiographic evidence of significant joint abnormality;
- non-surgical treatment has failed to adequately resolve the symptoms; and
- pain or dysfunction is moderate or severe.

Benefits for surgical services include, but are not limited to, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations. Benefits also include oral surgery to reduce a dislocation of, excisions of, and injection of the temporomandibular joint.

The Plan also provides Benefits for orthognathic surgery.

Benefits for an Inpatient Stay in a Hospital and Hospital-based Physician services are described in this section under *Hospital – Inpatient Stay* and *Physician Fees for Covered Services*, respectively.

Prior authorization is no longer required for Surgery of the jaw. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an Outpatient basis at a Hospital or Alternate Facility, including, but not limited to, dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an Outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when:

- education is required for a disease in which patient self-management is an important component of therapeutic treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services under this section include, but are not limited to:

- the Facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Covered Services*.

Benefits are paid as described under *Physician's Office Services* when these services are performed in a Physician's office.

Prior authorization is no longer required for Outpatient therapeutic treatments. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Therapies for Children with Developmental Delays

The Plan provides Benefits for rehabilitation and habilitation services Benefits for Dependent children with Developmental Delay that are determined to be necessary to, and provided in accordance with, an Individualized Family Service Plan issued by the Interagency Council on Early Childhood Intervention. Covered Health Services include:

- occupational therapy evaluations and services;
- physical therapy evaluations and services;
- speech therapy evaluations and services; and
- dietary or nutritional evaluations.

The Individualized Family Service Plan must be submitted to BCBSTX prior to beginning services and if there are changes to the Individualized Family Service Plan.

Once the child reaches the age of three, when services under the Individualized Family Service Plan are completed, Benefits are available as otherwise covered under this Plan. All provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

See also *Neurobiological Disorders - Autism Spectrum Disorder Services* under *Mental Health Services* in Section 6, *Details for Covered Health Services*.

Transplant Services

The Plan pays Benefits for transplant services Benefits only if Inpatient Facility services (including, but not limited to, evaluation for transplant, organ procurement and donor searches) for transplant procedures are ordered by a Physician. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. If the recipient is not a Participant in this Plan but the donor is a Participant in this Plan, then the recipient's plan is the Primary Plan and this Plan is the Secondary Plan for the donor's expenses in all cases, regardless of coordination of benefits rules to the contrary. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include, but are not limited to:

- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service;
- cornea;
- heart;
- heart/lung;
- intestinal;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- lung; and
- pancreas.

Donor costs directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan or through the donor's coverage under this Plan with the recipient's plan being the Primary Plan with this Plan being the Secondary Plan.The Plan has specific guidelines regarding transplant services Benefits. Contact BCBSTX at (800) 252-8039 (TTY: 711) for information about these guidelines.

Prior authorization is no longer required for Transplant Services. **However, it is recommended that your provider submit an RCR request to BCBSTX to confirm coverage, limitations and Medical Necessity prior to rendering services.** If your Provider chooses not to request RCR prior to rendering services, BCBSTX will conduct a post-service clinical review to determine if the Covered Health Service meets coverage requirements, Plan limitations, and Medical Necessity.

For more information, refer to Section 4, *Recommended Clinical Review (RCR)*.

Support in the event of serious illness
If you or a covered family member has cancer or is in need of an organ or bone marrow transplant, BCBSTX can put you in touch with quality treatment centers around the country. Please call BCBSTX at (800) 252-8039 (TTY: 711) for more information.

Urgent Care Center Services

The Plan provides Benefits for professional services received at an Urgent Care Center, as defined in Section 13, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Virtual Visits

The Plan covers Virtual Visits for certain Covered Health Services, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual Visits allow for the communication of medical information in real-time between the patient and a distant Physician, behavioral health clinician or health care Specialist, through use of interactive audio and video communications equipment outside of a medical Facility (for example, from home or work). A Virtual Visit should not be used in place of regular visits to your Physician.

Benefits are available only when services are delivered through a Virtual Network Provider. This Virtual Visits Benefit does not include local Providers who offer Telemedicine services. For more information, refer to Telemedicine above. You can find a Virtual Network Provider by going to **healthselectoftexas.com** and clicking on the medical benefits tab to access the Virtual Visits link or by calling BCBSTX at (800) 252-8039 (TTY: 711).

Please Note: Not all conditions can be appropriately treated through a Virtual Visit. The Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary. Some Virtual Visit Provider groups may list other services such as nutritional counseling or lactation services. These services are not covered by the Plan when received from a Virtual Network Provider.

Covered Benefits under this section do not include charges for email, fax and standard telephone calls, or for Telemedicine visits that occur within medical facilities, including facilities defined by the Centers for Medicare & Medicaid Services (CMS) as originating facilities.

For more information about Virtual Visits through Doctor on Demand and MDLIVE see *Addendum – Resources to Help You Stay Healthy*.

Vision Examinations

Covered Benefits include:

- vision screenings, which could be performed as part of an annual physical examination in a Provider's office (vision screenings do not include refractive examinations to detect vision impairment);
- one routine eye exam, including, but not limited to, refraction and glaucoma screening, to detect vision impairment by a Provider in the Provider's office every Calendar Year. Routine eye exams do not include contact lens exams; and
- non-routine or follow-up visits.

SECTION 7 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Details for Covered Health Services.*

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Details for Covered Health Services*, those limits are reflected in the corresponding Covered Health Service category in Section 5, *Schedule of Benefits and Coverage*. Additional limits may apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Schedule of Benefits and Coverage*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed the Benefit limits.

Please note that in listing services or examples, when the MBPD says "this includes," or "including, but not limited to," it is not the Plan's intent to limit the items to that specific list. When the Plan does intend to limit a list of services or examples, the MBPD specifically states that the list is limited to or covers only the specific items listed.

The Plan does not pay Benefits for the excluded services, treatments or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition. You are solely responsible for payment of charges for all services and supplies excluded by the Plan and described in this section.

The following services, treatments and supplies are excluded from coverage under the Plan:

Alternative Treatments

1. acupressure.
2. acupuncture.
3. aromatherapy.
4. hypnotism.
5. massage therapy except as described under *Rehabilitation Services - Outpatient Therapy in* Section 6, *Details for Covered Health Services*.
6. medical marijuana treatment or therapy, including but not limited to cannabinoid treatments and products such as oils, tinctures, and sprays.
7. rolfing (holistic tissue massage).
8. art therapy, music therapy, dance therapy, horseback therapy, wilderness experience therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Details for Covered Health Services.*

Dental

1. dental care, including, but not limited to, endodontics, periodontal surgery and restorative treatment, except as identified under *Dental Services* in Section 6, *Details for Covered Health Services.*
2. dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. An example of a non-covered item is treatment of dental caries resulting from dry mouth due to radiation treatment or medication.

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Details for Covered Health Services*.
3. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include, but are not limited to:

   - extractions (including, but not limited to, wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes.

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Details for Covered Health Services*.
4. dental implants, bone grafts, and other implant-related procedures.

   This exclusion does not apply to dental services for which Benefits are provided as described under *Dental Services* in Section 6, *Details for Covered Health Services*.
5. dental braces (orthodontics).
6. dental X-rays, supplies and appliances and all associated expenses, including, but not limited to, hospitalizations and anesthesia.

   This exclusion does not apply to:

   - dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition; or
   - hospitalization and anesthesia for certain Participants who cannot undergo local anesthesia.

   This exclusion does not apply to dental services for which Benefits are available under the Plan, as described in Section 6, *Details for Covered Health Services*.
7. treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities.
2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Details for Covered Health Services*:

   Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics or any orthotic braces available over the counter. This exclusion does not include podiatric appliances for the prevention of complications associated with diabetes as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.

3. the following items are excluded, even if prescribed by a Physician:
   - blood pressure cuff/monitor;
   - enuresis alarm;
   - non-wearable external defibrillator;
   - trusses;
   - ultrasonic nebulizers;
   - fully implantable prosthetics; and
   - prosthetics primarily designed to correct sexual dysfunction.
4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.
5. the replacement of lost or stolen prosthetic devices.
6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Details for Covered Health Services*.
7. oral appliances to reduce snoring.

Drugs

1. Outpatient prescription drugs for Outpatient use that are filled by a prescription order or refill. ***Note:*** Outpatient prescription medications are covered under the HealthSelect Prescription Drug Program (PDP). Go to **HealthSelectRx.com** for more information about covered Outpatient use prescription medications.
2. self-injectable medications, except as described under *Medications and Injections* in Section 6, *Details for Covered Health Services*.

   (This exclusion does not apply to medications which, due to their characteristics, as determined by the Plan, must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an Outpatient setting).

   Note: Insulin and certain self-injectable medications are Outpatient prescription medications covered under the HealthSelect Prescription Drug Program (PDP).
3. growth hormone therapy that is not Medically Necessary.
4. non-injectable medications given in a Physician's office except as required in an emergency and consumed in the Physician's office.
5. over-the-counter drugs, treatments and supplies.

Educational Services

1. Services that are Educational in nature, as defined in Section 13, *Glossary*.

   This exclusion does not apply to Diabetes Self-Management Training Programs for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.
2. Tuition for or services that are school based for children and adolescents under the *Individuals with Disabilities Education Act*.

Note: This exclusion does not apply to Covered Services (e.g., ABA) provided in an academic or educational setting if the Covered Services are Medically Necessary and not provided solely to allow participation in educational instruction.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, as described in Section 13, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*.

Foot Care

1. routine foot care services that include, but are not limited to:
   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue).

   This exclusion does not apply to foot care for severe systemic disease or preventive foot care for Participants with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.
2. hygienic and preventive maintenance foot care, except for Participants who are at risk of neurological or vascular disease arising from diseases such as diabetes. Examples include, but are not limited to:
   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and
   - other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.
3. treatment of flat feet.
4. treatment of subluxation of the foot.
5. arch supports.
6. shoe inserts, shoes (standard or custom), lifts and wedges and shoe orthotics.

   This exclusion does not include podiatric appliances for the prevention of complications associated with diabetes as described under *Diabetes Services* in Section 6, *Details for Covered Health Services* or when Medically Necessary as prescribed for circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy or chronic arterial or venous insufficiency.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical and disposable supplies. Examples of excluded supplies include, but are not limited to: compression stockings, ace bandages and wound care or dressing supplies purchased over the counter.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Details for Covered Health Services*;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Details for Covered Health Services*;
   - urinary catheters;
   - wound care or dressing supplies given by a Provider during treatment for Covered Health Services;
   - medical-grade compression stockings when considered Medically Necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient; and
   - diabetic equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Details for Covered Health Services*.
2. batteries, tubing, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.
3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect.
4. the replacement of lost or stolen Durable Medical Equipment.

Nutrition

1. services or supplies for Dietary and Nutritional Services, including home testing kits, vitamins, dietary supplements and replacements, and special food items, except an Inpatient nutritional assessment program provided in and by a Hospital and approved by BCBSTX.
2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, under *Therapies for Children with Developmental Delay Services* and under *Nutritional Counseling* in Section 6, *Details for Covered Health Services*.
3. enteral formulas and other nutritional and electrolyte formulas, including, but not limited to, infant formula and donor breast milk (infant formula available over the counter is always excluded) and home infusion therapy for over-the-counter fluids that do not require a prescription, including, but not limited to, standard nutritional formulations used for enteral nutrition therapy.

   This exclusion does not apply to:

   - enteral feedings or other nutritional formulas that are the only source or the majority of nutrition or that are specifically created to treat inborn errors of metabolism or heritable diseases such as phenylketonuria (PKU);
   - Medically Necessary amino acid-based elemental formulas that are used for the diagnosis and treatment of:
     - immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;

- severe food protein-induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by a biopsy; or
- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

4. food of any kind. Examples include, but are not limited to:
   - high-protein, low-protein or low-carbohydrate foods;
   - foods to control weight, treat obesity (including, but not limited to, liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary, nutritional and electrolyte supplements.
5. health education classes unless offered by BCBSTX or its affiliates, including, but not limited to, asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. beauty/barber service.
2. guest service.
3. health club membership and programs.
4. personal or comfort items, including but not limited to televisions, telephones, guest beds, admission kits, maternity kits and newborn kits provided by a Hospital or other Inpatient Facility.
5. breast pumps except as Benefits are provided under the federal Health Resources and Services Administration (HRSA) requirement as described under *Preventive Care Services* in Section 6, *Details for Covered Health Services.*
6. concierge fees
7. supplies, equipment and similar incidentals for personal comfort. Examples include, but are not limited to:
   - air conditioners;
   - air purifiers and filters;
   - batteries and battery chargers, except as described under *Hearing Aids* and under *Durable Medical Equipment* in Section 6, *Details for Covered Health Services*;
   - car seats;
   - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
   - dehumidifiers and humidifiers;
   - ergonomically correct chairs;
   - exercise equipment and treadmills;
   - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides);
   - hot tubs, Jacuzzis, saunas and whirlpools;
   - medical alert systems;

- music devices;
- non-Hospital beds, comfort beds, motorized beds and mattresses;
- personal computers;
- personal hygiene protection (for example, adult diapers);
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts; and
- video players.

Physical Appearance

1. services or supplies for Cosmetic, Reconstructive or Plastic Surgery, even when Medically Necessary, except as described in Reconstructive Procedures.

   Examples include, but are not limited to:

   - scar removal or revision procedures;
   - breast enhancement procedures;
   - a procedure or surgery to remove fatty tissue and/or hanging skin on any part of the body, even if hanging skin is due to weight loss or to Bariatric Surgery other covered under the Plan; and
   - removal or replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, spa treatments, and diversion or general motivational programs.
3. services or supplies for reduction of obesity or weight, including surgical procedures and prescription drugs, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under *Preventive Care Services*.

   This exclusion does not apply to:

   - Covered HealthSelect weight loss programs, currently Wondr and Real Appeal;
   - Bariatric Surgery Benefits if program eligibility criteria are met as described in Section 6-*Details for Covered Health Services*.
4. treatment of benign gynecomastia.

Procedures and Treatments

1. biofeedback.
2. tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
3. hair removal or treatments for hair loss by any means.
4. procedures and treatments for skin wrinkles or any procedure or treatment to improve the appearance of the skin, including, but not limited to, face lifts.
5. treatment for spider veins.
6. skin abrasion procedures performed as a treatment for acne.
7. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
8. rehabilitation services and Chiropractic Treatment to improve general physical condition that are provided to reduce potential risk factors and where significant therapeutic improvement is not expected, including, but not limited to, routine, long-term or maintenance/preventive treatment.
9. speech therapy, except as described under *Therapies for Children with Developmental Delay Services* or under *Rehabilitation Services – Outpatient Therapy* in Section 6, *Details for Covered Health Services*.
10. psychosurgery (lobotomy).
11. stand-alone multi-disciplinary smoking cessation programs. These programs usually include services by health care Providers specializing in smoking cessation, such as a psychologist or social worker, and also usually include intensive psychological support, behavior modification techniques and medications to control cravings.
12. chelation therapy, except to treat heavy metal poisoning.
13. services provided by a chiropractor to treat a condition unrelated to an identifiable neuromusculoskeletal condition, such as asthma or allergies, or services that do not meet the definition of Chiropractic Treatment shown in Section 13, *Glossary*.
14. therapy treatments or procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
15. gender reassignment surgery and services related to gender reassignment surgery.

    This exclusion does not apply to related mental health treatment.
16. non-surgical bariatric treatment, even if for morbid obesity.
17. Bariatric Surgery for Employees except as described under *Bariatric Surgery* in Section 6, *Details for Covered Health Services* or Bariatric Surgery for Dependents or Retirees.
18. oral appliances and devices used to treat TMJ pain disorders or dysfunction of the joint, jaw, jaw muscles and nerves.
19. the following services for the treatment of TMJ: any non-surgical treatment, including, but not limited to, clinical examinations, arthrocentesis and trigger-point injections; surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment and dental restorations.
20. health care services performed at a diagnostic Facility (Hospital or Alternate Facility) without a written order from a Provider.

21. health care services which are self-directed to a free-standing or Hospital-based diagnostic Facility.
22. health care services performed at a diagnostic Facility (Hospital or Alternate Facility), when ordered by a Provider affiliated with the diagnostic Facility and when that Provider is not actively involved in your care either prior to ordering the service or after the service is received. This exclusion does not apply to mammography testing or bone density screening.
23. breast reduction surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery that the Plan determines is for the treatment of a physiologic functional impairment or is coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Details for Covered Health Services*.
25. Mental Health Services as treatments for R-, T- and Z-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and/or Z codes listed within the current edition of the International Classification of Diseases (ICD) of the World Health Organization.

Providers

1. health care services performed by a Provider who is your family member by birth or marriage, including, but not limited to, your spouse, brother, sister, parent or child.
2. health care services that a Provider performs on himself or herself.
3. health care services performed by a Provider who has your same legal residence.
4. health care services performed by an unlicensed Provider or a Provider who is providing health care services outside of the scope of his/her license.
5. any annual fee, retainer or similar fee paid to a Provider.
6. self-treatment by a Provider as a part of their training; treatment by an individual or Facility outside the scope of licensed or otherwise authorized scope of practice.

Reproduction/Infertility

1. health services and associated expenses for infertility treatments, including, but not limited to, artificial insemination, intra-fallopian transfer or other assisted reproductive technology, regardless of the reason for the treatment. Also excluded are any services or supplies used in any procedure in preparation for or performed as a direct result of and immediately after any of the excluded procedures. This exclusion does not apply to services required to treat or correct underlying causes of infertility.

   Note: If a Pregnancy results from excluded infertility treatment, Pregnancy and newborn services will be covered as described under *Maternity Care* in Section 5, *Schedule of Benefits and Coverage* and Section 6, *Details for Covered Health Services*.
2. storage and retrieval of all reproductive materials (examples include, but are not limited to, eggs, sperm, testicular tissue and ovarian tissue).
3. in vitro fertilization regardless of the reason for treatment. Also excluded are any services or supplies used in any procedure in preparation for or performed as a direct result of and immediately after in vitro fertilization.
4. surrogate parenting, donor eggs, donor sperm and host uterus.
5. the reversal of voluntary sterilization.
6. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.

7. selective reduction surgery for multiple gestations.

   This exclusion does not apply if a Physician states the Participant's life would be endangered if the unborn child was carried to term.

8. elective surgical, non-surgical or drug induced Pregnancy termination. This exclusion does not apply if the Pregnancy termination is Medically Necessary.
9. services provided by a labor aide (doula).
10. parenting, pre-natal or birthing classes. This exclusion does not apply to breastfeeding counseling as mandated by the Affordable Care Act.

Services Provided Under Another Plan

Services for which coverage is available:

1. under another plan, except for Allowable Amounts payable as described in Section 9, *Coordination of Benefits (COB)*.
2. under workers' compensation, no-fault automobile coverage or similar plan if you could purchase or elect it or could have it purchased or elected for you.
3. while on active military duty.
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and Facilities are reasonably accessible, as determined by the Plan.

Transplants

1. any and all transplants of organs, cells, and other tissues, except as described in *Transplant Services* in Section 6, *Details for Covered Health Services*.
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (for example, a device that supports the heart while the patient waits for a suitable donor heart to become available)

Travel

1. travel, lodging or transportation expenses, even if ordered by a Physician. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Details for Covered Health Services*.

Types of Care

1. Custodial Care as defined in Section 13, *Glossary*, or maintenance care.
2. Domiciliary Care, as defined in Section 13, *Glossary.*
3. multi-disciplinary pain management programs provided on an Inpatient basis for acute pain or for exacerbation of chronic pain, unless determined by the Plan to be Medically Necessary.
4. Private Duty Nursing received on an Inpatient basis.
5. with respect to home health care, Hospice care, Outpatient Private Duty Nursing services or care received in a Skilled Nursing Facility or Inpatient Rehabilitation Facility, the following:

   - services provided for the convenience of the Participant or Participant's family, such as assistance with bathing, feeding, mobilizing, exercising or homemaking;
   - services as a "sitter" or companion; and

- general supervision of exercises taught to the Participant including, but not limited to, the actual carrying out of a maintenance program.

6. with respect to home health care, Hospice care or Outpatient Private Duty Nursing services, the following:
   - administration of oral medication;
   - periodic turning and positioning in bed;
   - food or home-delivered meals;
   - social casework or homemaker services; and
   - transportation services.
7. respite care (Skilled Care or unskilled care to provide relief for a permanent caregiver), unless provided as part of an integrated Hospice care program of services provided by a licensed Hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Details for Covered Health Services*.
8. rest cures.
9. services of personal care attendants.
10. work hardening programs (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. implantable lenses used only to correct a refractive error, including advanced lenses.
2. contact lens exams; purchase cost and associated fitting charges for eyeglasses or contact lenses. This exclusion does not apply to glasses or contact lenses following cataract surgery when Medically Necessary or contact lenses when prescribed to treat a Sickness or Injury of the cornea.
3. hearing aids not requiring a prescription
4. dispensing fees for hearing aids.
5. repairs to a hearing aid, even if the hearing aid purchase was a Covered Health Service under the Plan.
6. bone anchored hearing aids except when either of the following applies:
   - for Participants with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - for Participants with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid, as documented by a Physician.

   The Plan will not pay for more than one bone anchored hearing aid per Participant who meets the above coverage criteria during the entire period of time the Participant is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Participants who meet the above coverage are not covered, other than for malfunctions.
7. eye exercise or vision therapy, except any of the following therapies when ordered by a Physician to treat the specific related condition:
   - occlusion therapy for amblyopia;
   - prism adaptation therapy for esotropia; or,
   - orthoptic or vision therapy for convergence insufficiency.

8. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse.
2. charges for:
   - missed appointments;
   - room or Facility reservations;
   - completion of claim forms; and
   - record processing.
3. charges prohibited by federal anti-kickback or self-referral statutes.
4. diagnostic tests that are:
   - delivered in other than a Physician's office or health care Facility; or
   - self-administered home diagnostic tests, including but not limited to, HIV and Pregnancy tests, except for Cologuard screening as defined in Section 6, *Details for Covered Health Services.*
5. expenses for health services and supplies:
   - that would otherwise be considered Covered Health Services and are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Participants who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
   - that are received after the date your coverage under this Plan ends, including health services for conditions that began before the date your coverage under the Plan ends;
   - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Plan;
   - that exceed Allowable Amounts or any specified limitation in this MBPD; or
   - for which a Non-Network Provider waives the Copay, Annual Non-Network Deductible or Coinsurance amounts.
6. foreign language and sign language services.
7. long term (more than 30 days) storage of blood, umbilical cord or other biological material. Examples include, but are not limited to, cryopreservation of tissue, blood and blood products.
8. health services and supplies that do not meet the definition of a Covered Health Service as shown in Section 13, *Glossary*.
9. health services related to a non-covered Health Service: When a service is not a Covered Health Service, all non-emergency services related to that non-covered Health Service are also excluded.

This exclusion does apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-covered Health Service even if the treatment of the complication is considered to be Medically Necessary, prescribed by a Physician or if the Participant has medical or psychological conditions that could be helped by the surgery, services, supplies, treatments, or procedures.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

The plan may cover reasonable and necessary medical or hospital services after a patient is discharged from a hospital stay for non-covered services, and then needs services to treat a condition or complication that resulted from the non-covered services. The plan does not pay for subsequent services normally incorporated into a global fee.

10. physical, psychiatric or psychological exams, testing, vaccinations, immunizations, treatments, or vocational counseling when:

    - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.

SECTION 8 - CLAIMS PROCEDURES

What this section includes

- How Network and Non-Network health claims work; and
- What you may do if your health claim is denied, in whole or in part.

Note: You may designate an Authorized Representative who has the authority to represent you in all matters concerning your claim or appeal of a claim determination. If you have an Authorized Representative, any references to "you" or "Participant" in this Section 8 will refer to the Authorized Representative. See *Authorized Representative* below for details.

Claims Processing for Network and Non-Network Benefits

BCBSTX has a nationwide Network of participating Providers. Claims processing for Benefits depends on whether you receive Covered Health Services from a Network or a Non-Network Provider.

Network Benefits

In general, if you receive Covered Health Services from a Network Provider, BCBSTX will pay the Physician or Facility directly. If a Network Provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the Provider or call BCBSTX at (800) 252-8039 (TTY: 711) for assistance.

Keep in mind, you are responsible for paying any Copay or Coinsurance owed to a Network Provider at the time of service, or when you receive a bill from the Provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network or Non-Contracted Provider, you (or the Provider if they prefer) must send the bill to BCBSTX for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to BCBSTX at the following address:

Blue Cross and Blue Shield of Texas – Claims
P.O. Box 660044
Dallas, Texas 75266-0044

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **healthselectoftexas.com**, calling BCBSTX at (800) 252-8039 (TTY: 711) or contacting your Benefits Coordinator. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the Participant's name, age and relationship to the Subscriber;
- the ID number as shown on your HealthSelect medical ID card;
- the name, address and tax identification number of the Provider of the service(s);
- a diagnosis from the Physician;

- the date of service;
- an itemized bill from the Provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - a statement indicating either that you are, or you are not, enrolled in coverage under any other health insurance plan or program. If you are enrolled in other coverage, you must include the name and address of the other insurer(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with BCBSTX at the following address:

Blue Cross and Blue Shield of Texas – Claims
P.O. Box 660044
Dallas, Texas 75266-0044

Intentionally false statements of material fact may result in adverse action against you, including, but not limited to, termination of your health coverage and expulsion from the GBP.

An act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact, as prohibited by the terms of the Plan or coverage, may result in rescission of coverage. Prior to rescinding coverage, the Plan shall provide at least thirty (30) days advance written notice to each Participant who would be affected.

Claim Payment and Assignment

After BCBSTX has processed your claim, you will receive payment for Benefits that the Plan allows. If you have used a Non-Network Provider or Non-Contracted Provider, it is your responsibility to pay the Non-Network Provider or Non-Contracted Provider the charges you incurred. If you used a Non-Contracted Provider, it is your responsibility to pay the Non-Contracted Provider any difference between what you were billed and what the Plan paid.

Providers may not bill you for amounts exceeding your Participant responsibility for Deductibles, Copayments, and Coinsurance as part of the Plan Allowable Amount if you receive services from a Non-Network Provider performed at a Network Facility, or Non-Network laboratory or diagnostic imaging services in connection with care delivered by a Network Provider, without your advance, written agreement. See Section 3, *How the Plan Works*, under the heading *Accessing Benefits* for more information.

BCBSTX will pay Benefits to you unless:

- the Provider notifies BCBSTX that you have provided signed authorization to assign Benefits directly to that Provider; or
- you make a written request for the Non-Network or Non-Contracted Provider to be paid directly at the time you submit your claim.

BCBSTX will only pay Benefits to you or, with written authorization by you, to your Provider, and not to a third party, even if your Provider has assigned Benefits to that party.

Explanation of Benefits (EOB)

BCBSTX will send you a paper copy of an Explanation of Benefits (EOB) after processing each of your submitted claims. The EOB will let you know the amount you are responsible for. If any claim is denied in whole or in part, the EOB will include the reason for the denial or partial payment. Please note that your EOB will not reflect amounts you may have already paid to the Provider. If you would like to stop receiving paper copies of the EOBs and only receive EOBs electronically, you may "go green" and turn off paper copies online at **healthselectoftexas.com**. See Section 13, *Glossary*, for the definition of Explanation of Benefits. If you do not receive an EOB or would like a copy of your EOB, call a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711).

Note: Upon receipt of a claim from your Provider, BCBSTX may need to request additional information including medical records. BCBSTX will work directly with your Network Provider to obtain the information needed.

Timely Filing Claim Limitations

Claims for services rendered must be filed within certain time limits to be eligible for Benefits and payment under the Plan.

Network Provider Timely Filing Limitations

If you receive services from a Network Provider, your Provider is required to submit claims to BCBSTX within 180 days from the date of service. If the claim is not submitted by your Provider within 180 days from the date of service, the claim will be denied as not timely filed, and no Benefits will be paid to your Provider. You are not responsible for payment to a Network Provider for any services or claims not submitted timely by the Network Provider to BCBSTX.

Non-Contracted Provider Timely Filing Limitations

If you received services from a Non-Contracted Provider, you may be required to pay up front and file the claim to BCBSTX for the services rendered. For details on how to file a claim, see *If Your Provider Does Not File Your Claim,* in this Section. Your claim submission for Non-Contracted services must be received by BCBSTX within 18 months from the date of the service. If your submitted Non-Contracted service claim is received by BCBSTX more than 18 months from the date of service, the claim will be denied as not timely filed, and Benefits will not be paid to you or your Provider.

If you receive services from a Non-Contracted Provider in the state of Texas, the Provider has 95 days, from the date of service, to file the claim to BCBSTX. If the Non-Contracted Provider submitted claim is received by BCBSTX more than 95 days from the date of service, the claim will be denied as not timely filed, and Benefits will not be paid to you or your Provider.

If you receive services from a Non-Contracted Provider outside the state of Texas, the Provider has 12 months, from the date of service, to file the claim to BCBSTX. If the claim submitted by your Provider is received BCBSTX more than 12 months from the date of service, the claim will be denied as not timely filed, and Benefits will not be paid to you or your Provider.

Non-Contracted Providers can bill you for services that are ineligible for Benefits under the Plan because a claim was not submitted timely for payment to BCBSTX. To avoid additional cost, you should discuss services you will receive with the Non-Contracted Provider prior to receiving care.

Claim Denials and Appeals

If Your Claim Is Denied

If a claim for Benefits is denied in part or in whole, you may call BCSTX at (800) 252-8039 (TTY: 711) before requesting a formal appeal. If BCBSTX cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

BCBSTX may use one or more affiliated entities to provide utilization management services. Those services may include review for Medical Necessity determination and one or more review stages related to an appeal. The timing and process of each appeal remains generally the same regardless of which entity is conducting the appeal. You may receive a letter from an entity affiliated with BCBSTX with instructions for proper routing of your appeal during the first or second appeal stage. These letters also include the Plan's logo to indicate that they are associated with HealthSelect. You may always call BCBSTX at (800) 252-8039 (TTY: 711) with any questions.

How to Appeal a Denied Claim

If you wish to appeal a denied Pre-Service Request for Benefits, concurrent claim, or Post-Service Claim, you or your Authorized Representative must submit your appeal within 180 days of receiving the adverse benefit determination. Appeals can be submitted in writing via mail, fax, or secure message within your Blue Access for Members account. You may also initiate an appeal verbally by calling a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711). The following information should be provided:

- the Participant's name and ID number as shown on the HealthSelect medical ID card;
- the Provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your appeal.

You or your Authorized Representative may send a written appeal to:

Blue Cross and Blue Shield of Texas - Appeals
P. O. Box 660044
Dallas, Texas 75266-0044

You do not need to submit appeals in writing for Urgent Requests for Benefits. For denied Urgent Requests, you or your Provider can call BCBSTX at (800) 252-8039 (TTY: 711) to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent Request for Benefits;
- Pre-Service Request for Benefits;
- concurrent care claim;
- Post-Service Claim; or
- rescission of coverage.

First Internal Appeal

BCBSTX will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial Benefit determination process.

Once the review is complete, if BCBSTX upholds the denial, you and your Provider will receive a written explanation of the reasons and facts relating to the denial and a description of the additional appeal procedures. If BCBSTX overturns the denial, you and your Provider will receive notification of its decision and Benefits will be paid, as appropriate.

Notes:

- A denial of Benefits for services does not mean that you cannot receive the services. A denial of the Benefits means the services are not covered by the Plan and payments are not made by the Plan to you or any Providers by the Plan if you receive the denied services unless a subsequent appeal overturns the initial denial of benefits.
- If your Urgent Request for Benefits was denied, you may request an expedited external review at the same time you request an expedited internal appeal to BCBSTX. BCBSTX will review the request to determine if the appeal should go directly to the expedited external review instead of through the internal appeal process. If the request for appeal does not meet the expedited external appeal criteria as determined by BCBSTX, the appeal will be handled as an expedited internal appeal to BCBSTX.

Second Internal Appeal to Blue Cross and Blue Shield of Texas of an Urgent Request for Benefits, a Pre-Service Request for Benefits, or a Concurrent Claim

If you are not satisfied with the first internal appeal decision regarding an Urgent Request for Benefits, a Pre-Service Request for Benefits, or a concurrent claim, you have the right to request a second internal appeal from BCBSTX. You must file a written request for the second internal appeal within 60 days from your receipt of the first internal appeal determination notification.

If you do not request a second internal appeal from BCBSTX within 60 days from your receipt of the first internal appeal determination notification, the denial will be upheld due to untimely filing.

If your non-urgent Pre-Service Request for Benefits is denied, you may file a second internal appeal to BCBSTX. If the denial is upheld at the second internal appeal level, BCBSTX will notify you of the reason(s) for its decision and that your internal appeal options are exhausted. If the appeal involves issues of medical judgment, you may request an external review. If BCBSTX overturns its decision at the second internal appeal level, BCBSTX will notify you of its decision and Benefits will be paid, as appropriate.

Note: Upon written request, Participants may examine documents relevant to their claims and/or appeals at no cost and submit opinions and comments. BCBSTX will review all claims in accordance with the rules established by the U.S. Department of Labor.

For more information on the appeals process, see the ERS' Participant Guide to the Appeal Process at **ers.texas.gov/PDFs/GBP-Appeal-Process-Precedent-Manual**.

Second Internal Appeal to ERS of a Post-Service Claim

If you are not satisfied with the first internal appeal decision regarding a Post-Service Claim, you have the right to request a second internal appeal from ERS. You must file a written request for the second internal appeal within 90 days from your receipt of the first level appeal determination notification. If you do not request a second internal appeal from ERS within 90 days from your receipt of the first level appeal determination notification, the denial will be upheld due to untimely filing.

If ERS upholds the denial at the second internal appeal level, ERS will notify you of the reasons for its decision and that your internal appeal options are exhausted. If your appeal involves issues of medical judgment, you may request an external review. If ERS overturns the denial, BCBSTX will notify you and Benefits will be paid, as appropriate.

ERS does not review denials of Pre-Service Requests for Benefits, Urgent Requests for Benefits or concurrent claims.

Appeal to ERS of a Rescission of Coverage

Rescission is the cancellation or discontinuance of coverage that has retroactive effect. Your coverage may not be rescinded unless you or a person seeking coverage on your behalf performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage that has only prospective effect is not a rescission. A retroactive cancellation or discontinuance of coverage based on a failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums) is not a rescission. You will be given 30 days advance notice of rescission. A rescission is considered an adverse benefit determination for which you may seek internal review and external review.

If your coverage is rescinded by ERS, you have the right to request an internal appeal from ERS. Your notification of rescission will contain instructions for filing an appeal. You must file a written request for the internal appeal within 180 days from your receipt of the rescission notification. If you do not request an appeal from ERS within 180 days from your receipt of the rescission notification, the rescission will be upheld due to untimely filing.

If ERS upholds the rescission of coverage, ERS will notify you of the reason(s) for its decision and that your internal appeal options are exhausted. You may request an external review of the denial of your appeal related to a rescission of coverage.

Timely Review

BCBSTX and ERS will complete reviews within legally applicable time periods; however, BCBSTX and ERS have the right to an extension under certain circumstances.

Mediation/Arbitration Rights

There are mediation or arbitration rights under Chapter 1467 of the Texas Insurance Code. You may refer to your EOB for specific information about any available mediation or arbitration rights.

You should not be billed for any amounts above your responsibility for Deductibles, Copays and Coinsurance in the following instances:

- Emergency Services or supplies you receive from a Non-Network Provider;
- Services from a Non-Network Provider that you receive in a Network Facility, unless you agreed in writing in advance to receive the Non-Network services; or

- Lab or diagnostic imaging services you receive from a Non-Network lab or diagnostic imaging service that were ordered by a Network Provider unless you agreed in writing in advance to receive the Non-Network services.

If you receive a bill for amounts above your responsibility in the scenarios listed above without providing your written consent in advance, please contact a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711).

Tables 5 through 8 below describe the time frames which you and BCBSTX are required to follow.

TABLE 5	
Urgent Request for Benefits[1]	
Action to Be Taken	**Timing[2]**
If your Request for Benefits is complete, BCBSTX must notify you within:	**72 hours**
If your Request for Benefits is incomplete, BCBSTX must notify you that it is incomplete within:	**24 hours**
You must then provide the completed Request for Benefits to BCBSTX within:	**48 hours** after receiving notice of additional information required
BCBSTX must notify you and your Provider of the benefit determination within:	**48 hours after receipt of additional information**
If BCBSTX denies your Request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
BCBSTX must notify you of the first internal appeal decision within:	**72 hours** after receiving the appeal

[1]You do not need to submit Urgent appeals in writing. You should call BCBSTX as soon as possible to appeal an Urgent Request for Benefits.

[2]From when the request is made unless otherwise noted below.

TABLE 6	
Pre-Service Request for Benefits	
Action to Be Taken	**Timing**[1]
If your Request for Benefits is filed improperly with BCBSTX, it must notify you within:	**5 days**
If your Request for Benefits is incomplete BCBSTX must notify you within:	**15 days**
You must then provide completed Request for Benefits information to BCBSTX within:	**45 days**
BCBSTX must notify you of the Benefit determination:	
if your Request for Benefits is complete, within:	**15 days**
after receiving the completed Request for Benefits (if your Request for Benefits was incomplete as filed), within:	**15 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
BCBSTX must notify you of the first internal appeal decision within:	**15 days** after receiving the first internal appeal
You must appeal the denial of your first internal appeal (by filing a second internal appeal) no later than:	**60 days** after receiving the first internal appeal decision
BCBSTX must notify you of the second internal appeal decision within:	**15 days** after receiving the second internal appeal

[1]From when the request is made unless otherwise noted below.

TABLE 7	
Post-Service Claims	
Action to Be Taken	**Timing**[1]
If your claim is incomplete, BCBSTX must notify you within:	**30 days**
You must then provide completed claim information to BCBSTX within:	**45 days**
BCBSTX must notify you of the Benefit determination:	
if the claim was complete as filed, within:	**30 days**
after receiving the completed claim (if the claim was incomplete as filed), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
BCBSTX must notify you of the first internal appeal decision no later than:	**30 days** after receiving the first internal appeal
You must appeal the denial of your first internal appeal (by filing a second internal appeal with ERS) no later than:	**90 days** after receiving the first internal appeal decision
BCBSTX or ERS must notify you of the second internal appeal decision within:	**30 days** after receiving the second internal appeal

[1]From when the request is made unless otherwise noted below.

TABLE 8	
Rescission of Coverage	
Action to Be Taken	**Timing**[1]
You must appeal a rescission of coverage, which is an adverse benefit determination, to ERS no later than:	**180 days** after receiving the adverse benefit determination
ERS must notify you of the final internal appeal decision no later than:	**60 days** after receiving the first internal appeal

[1]From when the request is made unless otherwise noted below.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by BCBSTX or ERS, or if BCBSTX or ERS fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an immediate external review of the determination made by BCBSTX or ERS. The process is available at no charge to you.

A request for an external review of an adverse benefit determination may be based upon any of the following:

- clinical reasons (the determination involves a question of medical judgment);
- rescission of coverage (coverage that was terminated retroactively); or
- as otherwise required by applicable law.

Note: You may also have the right to pursue external review in the event that BCBSTX or ERS failed to comply with the internal claims and appeals process, except for those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you.

You or your Authorized Representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your Authorized Representative may request an expedited external review, in urgent situations as detailed below, by calling BCBSTX at (800) 252-8039 (TTY: 711) or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you receive BCBSTX' or ERS' determination.

An external review request should include all of the following:

- a specific request for an external review;
- the Participant's name, address, and insurance ID number;
- your Authorized Representative's name and address, when applicable;
- the service that was denied, the date of service, the Provider's name; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). BCBSTX has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by BCBSTX of the request;
- a referral of the request by BCBSTX to the IRO;
- the review by the IRO; and
- a decision by the IRO.

Within the applicable time frame after receipt of the request, BCBSTX will complete a preliminary review to determine whether the Participant for whom the request was submitted meets all of the following:

- was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that BCBSTX may process the request.

After BCBSTX completes the preliminary review, BCBSTX will issue you a notification in writing within five business days of receiving the request for the external review. If the request is eligible for external review, BCBSTX will assign an IRO to conduct such review. BCBSTX will assign IRO requests by either rotating claims assignments among the IROs or by using a random selection process.

BCBSTX will provide the assigned IRO with the documents and information considered in making BCBSTX' or ERS' determination. The documents include:

- all relevant medical records;
- all other documents relied upon by BCBSTX or ERS;
- all other information or evidence that you or your Provider submitted regarding the claim; and
- all other information or evidence that you or your Provider wish to submit regarding the claim, including, as explained below, any information or evidence you or your Provider wish to submit that was not previously provided.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date you receive notice from the IRO, any additional information that you want the IRO to consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days. In reaching a decision, the IRO will review the claim anew and will not be bound by any decisions or conclusions reached by BCBSTX or ERS. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless the IRO requests additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and BCBSTX, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing BCBSTX' or ERS' determination, BCBSTX will notify you within 48 hours of receiving the IRO's decision. The Plan will immediately provide coverage or payment of the Benefits at issue in accordance with the terms and conditions of the Plan. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure, and you will have exhausted your appeal rights.

All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a condition for which the time frame for completion of a standard internal appeal would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- a final appeal decision, if the determination involves a condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the Participant received emergency services, but has not been discharged from a Facility.

Immediately upon receipt of the request, BCBSTX will determine whether the Participant meets both of the following:

- was covered under the Plan at the time the service or procedure that is at issue in the request was provided; and
- has provided all the information and forms required so that BCBSTX may process the request.

After completing the review, BCBSTX will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, BCBSTX will assign an IRO in the same manner BCBSTX utilizes to assign standard external reviews to IROs. BCBSTX will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by BCBSTX. The IRO will provide notice of the Final External Review Decision for an expedited external review as expeditiously as the Participant's condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO's notice of the Final External Review Decision is not in writing, within 48 hours of providing such notice, the assigned IRO will provide written confirmation of the decision to you and to BCBSTX.

All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

You may contact BCBSTX at (800) 252-8039 (TTY: 711) for more information regarding external review rights, or if making a verbal request for an expedited external review.

Table 9 below describes the time frames which you, BCBSTX and the IRO are required to follow.

TABLE 9	
External Review	
Action to Be Taken	**Timing**[1]
You must submit a request for external review to BCBSTX within:	**Four months** after the date you receive the second internal appeal determination
For an expedited external review, the IRO will provide notice of its determination within:	**72 hours**
For a standard external review, BCBSTX will complete a preliminary review to ensure the request meets requirements for an external review within:	**5 business days**
You may submit in writing to the IRO any additional information that you want the IRO to consider within:	**10 business days**
For a standard external review, the IRO will provide written notice of its determination within:	**45 days**[2] after receiving the request for the external review

[1]From when the request is made unless otherwise noted below.

[2]This time frame may be extended if the IRO requests additional time and you agree.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

BCBSTX will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Request for Benefits and decided according to the time frames described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service time frames, whichever applies.

Authorized Representative

A Participant may have one Authorized Representative, and only one Authorized Representative at a time, to assist in submitting a claim or appealing a claim.

An Authorized Representative shall have the authority to represent the Participant in all matters concerning the Participant's claim or appeal of a claim determination. If the Participant has an Authorized Representative, any references to "you" or "Participant" in this Section 8 will refer to the Authorized Representative.

One of the following persons may act as a Participant's Authorized Representative:

- an individual designated by the Participant in writing on a form approved by BCBSTX;
- a health care Provider designated by the Participant in writing on a form approved by BCBSTX. For Urgent Care claims, a health care Provider may act as a Participant's Authorized Representative without the Participant's written designation;
- a person holding the Participant's durable power of attorney;
- if the Participant is legally incapacitated, a person appointed as guardian of the Participant by a court of competent jurisdiction; or
- if the Participant is a minor, the Participant's parent or legal guardian, unless BCBSTX is notified that the Participant's claim involves health care services where the consent of the Participant's parent or legal guardian is or was not required by law, in which case the Participant may represent himself or herself with respect to the claim.

The authority of an Authorized Representative shall continue for the period specified in the Participant's appointment of the Authorized Representative or until the Participant is legally competent to represent himself or herself and notifies BCBSTX in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative

1. If the Authorized Representative represents the Participant because the Authorized Representative is the Participant's parent or legal guardian or attorney in fact under a durable power of attorney, BCBSTX shall send all correspondence, notices and benefit determinations in connection with the Participant's Claim to the Authorized Representative.
2. If the Authorized Representative represents the Participant in connection with the submission of a Pre-Service Claim, including a claim involving Urgent Care, BCBSTX shall send all correspondence, notices and benefit determinations in connection with the Participant's claim to the Authorized Representative.
3. If the Authorized Representative represents the Participant in connection with the submission of a Post-Service Claim, BCBSTX will send all correspondence, notices and benefit determinations in connection with the Participant's Claim to the Participant and the Authorized Representative.
4. It can take BCBSTX 30 days or more to notify all of its personnel about the termination of the Participant's Authorized Representative. It is possible that BCBSTX may communicate information about the Participant to the Authorized Representative during this 30-day period.

SECTION 9 – COORDINATION OF BENEFITS (COB)

What this section includes

- How your Benefits under this Plan coordinate with other medical plans;
- How your coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including, but not limited to, any one of the following:

- another employer-sponsored health benefits plan;
- another group insurance plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal Injury protection benefits under an automobile insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

COB does not apply if your other health plan is a health insurance policy that is individually underwritten or issued and prohibits COB. We recommend that you check with your other health plan administrator if you are not sure if that plan prohibits COB.

Note: No-fault, fault, personal injury protection and liability coverage plans do not normally contain order of benefit determinations provisions and would typically be Primary. When payment is made by this Plan as the Primary payor when another party should have paid as the Primary payor, this Plan will request reimbursement.

If coverage is provided under two or more plans, COB determines which plan is Primary and which plan is Secondary. The plan considered Primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Eligible allowable expense may be paid under the other plan, which is considered Secondary. The Secondary Plan may determine its benefits based on the benefits paid by the Primary Plan.

Don't forget to update your Dependents' Health Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's health coverage information. Visit **healthselectoftexas.com** or call BCBSTX at (800) 252-8039 (TTY: 711) to update your COB information. You will need the name of your Dependent's other health coverage, along with the policy number.

Determining Which Plan Is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- a plan that covers a Participant as an employee pays benefits before a plan that covers the Participant as a dependent;
- the plan that covers an active employee pays before a plan covering a laid-off or retired employee;
- your Dependent children will receive Primary coverage from the parent whose birth date occurs first in a Calendar Year. If both parents have the same birth date, the plan that that has been in effect the longest is the Primary Plan. This birthday rule applies only if:

  - the parents are married or living together whether or not they have ever been married and not legally separated; or
  - a court decree awards joint custody to the parents without specifying that one parent has the responsibility to provide health care coverage.
- if two or more plans cover a Dependent child of divorced or separated parents and if there is not a court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
  - the parent with custody of the child; then
  - the spouse of the parent with custody of the child; then
  - the parent not having custody of the child; then
  - the spouse of the parent not having custody of the child;
- if you are covered as an active employee by two plans, or you are covered as a retiree by two plans, the plan that has covered the individual claimant for the longest period will pay first; the expenses must be covered in part under at least one of the plans;
- if you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will be the Primary Plan;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan is the Primary Plan; and
- finally, if none of the above rules determines which plan is Primary or Secondary, the allowable expenses shall be shared equally between the plans meeting the definition of an eligible plan for COB purposes.

Under any of the circumstances above, this Plan will not pay more than it would have paid had it been the only plan in effect.

In general, if you are an Employee and covered under this Plan, this Plan will be the Primary Plan and would apply to you and any of your covered Dependents even if they are enrolled in Medicare coverage.

When you retire and are Medicare eligible, the order of your coverage in this Plan changes. When you are an active Employee, you do not get to choose a Medicare Primary Plan.

For more information on how eligibility and enrollment for Medicare impact this Plan's Coordination of Benefits provisions, see the *Section 2- Introduction* and the header *When a Participant Qualifies for Medicare* in this Section.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples
1) Let's say you and your spouse both have family health coverage through your respective employers. You are ill and visit your Physician. Since you're covered as a Subscriber under this Plan, and as a Dependent under your spouse's plan, this Plan will pay Benefits for your Physician's office visit first.

2) Again, let's say you and your spouse both have family health coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your spouse's birthday to determine which plan pays first. If you were born on June 11 and your spouse was born on May 30, your spouse's plan will pay first.

Table 10 summarizes common situations of dual coverage and whether HealthSelect would be considered the Primary Plan or the Secondary Plan.

TABLE 10		
Subscriber is…	**…and is covered as a dependent under another plan by:**	**…then HealthSelect is:**
an Active Employee	spouse's employer plan	the Primary Plan
an Active Employee	spouse's retiree plan	the Primary Plan
a Retiree*	spouse's employer plan	the Primary Plan
a Retiree*	spouse's retiree plan	the Primary Plan
Subscriber is…	**…and has other coverage through:**	**…then HealthSelect is:**
an Active Employee	the Subscriber's second active employment	either Primary or Secondary depending on which plan is in force the longest
an Active Employee	the Subscriber's retirement from another employer	the Primary Plan
a Retiree*	the Subscriber's second active employment	the Secondary Plan
a Retiree*	the Subscriber's retirement from another employer	either Primary or Secondary depending on which plan is in force the longest
HealthSelect enrolled Dependent is…	**…and is covered by a Subscriber who is:**	**…then HealthSelect is:**
an active employee of a non-GBP Employer	an Active Employee	the Secondary Plan
an active employee of a non-GBP Employer	a Retiree	the Secondary Plan
a retiree of a non-GBP Employer	an Active Employee	the Primary Plan
a retiree of a non-GBP Employer	a Retiree	the Secondary Plan

*See *Section 2- Introduction* and this Section under the header *When a Participant Qualifies for Medicare* for more information on how this Plan works when a Retiree is eligible for Medicare coverage.

When This Plan Is Secondary

When this Plan is the Secondary Plan, the Plan determines the amount it will pay for a Covered Health Service according to the following:

- this Plan determines the amount it would have paid based on its Allowable Amount.
- this Plan pays the difference between the amount paid by the Primary Plan and this Plan's Allowable Amount.
- this Plan does not pay more than the Allowable Amount this Plan would have paid had it been the only plan providing coverage.
- the maximum combined payments from all plans cannot exceed 100% of this Plan's Allowable Amount as determined by this Plan.
- this Plan's Benefits may be reduced because of the Primary Plan's benefits.

Determining the Allowable Amount When This Plan Is Secondary

If this Plan is Secondary and the health care services meet this Plan's definition of a Covered Health Service, this Plan will determine its Allowable Amount using the methodology described in Section 3- *How the Plan Works*, under the heading *Allowable Amounts*.

The Allowable Amount is the maximum amount this Plan will pay for Covered Health Services you receive. If you receive services from a Network Provider, you are not responsible for the difference between the amount determined as your patient share by the Primary Plan and the HealthSelect Allowable Amount. When the Primary Plan payment and the amount paid by this Plan are equal to the HealthSelect Allowable Amount, you pay $0. If you receive Covered Health Services from a Non-Network Provider, you may be responsible for additional amounts.

Example: Below is an example of how COB works when you have two health plans, and this Plan is the Secondary Plan.

Primary Plan	**Amount Billed by Provider**	**Primary Plan's allowable expense**	**Primary Plan Payment**	**Patient Share**
	$1,000.00	$500.00	$100.00	$400.00
Secondary Plan (HealthSelect)	**Amount Billed by Provider**	**Secondary Plan's Allowable Amount**	**Secondary Plan Payment**	**Patient Share**
	$1,000.00	$400.00	$300.00 (payment is this Plan's Allowable Amount less the Primary Plan Payment)	$0.00

You are not responsible for any amount exceeding your patient share as shown on the HealthSelect Explanation of Benefits (EOB) document.

When a Participant Qualifies for Medicare

Determining Which Plan Is Primary

To the extent permitted by law, this Plan pays Benefits as the Secondary Plan to Medicare when you become eligible for Medicare, even if you don't enroll in Medicare. There are, however, certain conditions when the Plan pays Benefits first and Medicare pays benefits second:

- persons who are Actively at Work with a State Agency or with an Institution of Higher Education and their spouses; and
- individuals with End-Stage Renal Disease (ESRD) for a limited period of time, as determined by Medicare. Current federal legislation related to Medicare for individuals with End-Stage Renal Disease states that group health plan coverage will be Primary for 30 months (during your coordination period). After the coordination period, Medicare is the Primary Plan, and this plan is Secondary. If you do not enroll in Medicare Part B prior to Medicare becoming your Primary Plan, Benefits payable under the Plan will be reduced, and that amount could be significant. For more information regarding ESRD and Coordination of Benefits visit **Medicare.gov**.

If you are Actively at Work and not Medicare-eligible but your spouse is Medicare-eligible (for reasons other than End-Stage Renal Disease), this Plan will be Primary for your spouse if he or she is your Dependent.

If you are a Retiree and are Medicare-eligible but are actively employed and covered under another group health plan through that employer, then your active coverage will be Primary, Medicare will be Secondary and this Plan will be Tertiary (i.e., will pay third).

Determining the Allowable Amount When This Plan Is Secondary to Medicare

If this Plan is Secondary or Tertiary to Medicare, the Medicare-Approved Amount is the Allowable Amount, as long as the Provider accepts Medicare Assignment. If the Provider does not accept Medicare Assignment, the Medicare Limiting Charge (the most a Provider can charge you if they don't accept Medicare Assignment) is the Allowable Amount. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Amount.

If you retired and turned age 65 on or before September 1, 1992, Medicare is the Primary Plan, and this Plan is the Secondary Plan for Medicare Part A Benefits. However, if you do not have Medicare Part B, this Plan is the Primary Plan for Part B Benefits, making Medicare the Secondary Plan for Part B Benefits. This also applies to your covered spouse if he or she turned age 65 on or before September 1, 1992.

If you retired after September 1, 1992, or if you are the Dependent of a Subscriber who retired after September 1, 1992, and you are eligible for Medicare, this Plan is the Secondary or Tertiary Plan to Medicare Part A and Part B Benefits for you and your covered spouse, whether or not you are enrolled in Medicare.

If you are a Retiree and qualify for Medicare, and you do not enroll in Medicare Part B during open enrollment, the Plan will pay for Covered Health Services at 20% of the Plan's Allowable Amount as described under *How the Plan Works* in Section 3, *Allowable Amount*.

If you are a Retiree and are not eligible for Medicare Part A because you or your spouse did not contribute to Social Security, this Plan will be the Primary Plan for Medicare Part A Benefits if no other health coverage is available to you or your covered spouse. However, unless you retired and turned age 65 on or before September 1, 1992, this Plan is the Secondary Plan to Medicare Part B Benefits.

When This Plan Is Tertiary

When this Plan is the Tertiary Plan, the Plan determines the amount it will pay for a Covered Health Service according to the following:

- the Plan determines the amount it would have paid based on its Allowable Amount.
- After both the Primary Plan and the Secondary Plan have paid, the Plan pays the difference between the amount paid by the Primary and Secondary Plans and this Plan's Allowable Amount.
- this Plan does not pay more than the Allowable Amount this Plan would have paid had it been the only plan providing coverage.
- the maximum combined payments from all plans cannot exceed 100% of this Plan's total Allowable Amount as determined by this Plan.
- this Plan's Benefits may be reduced because of the Primary Plan and Secondary Plan's benefits.

Medicare Crossover Program

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you do not have to file a separate claim with the Plan to receive Secondary Benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only Secondary health coverage.

Once the Medicare Part A and Part B and DME carriers have reimbursed your health care Provider, the Medicare carrier will electronically submit the necessary information to BCBSTX to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the Medicare Summary Notice (MSN) states your claim has been forwarded to your Secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call BCBSTX at (800) 252-8039 (TTY: 711).

Overpayment and Underpayment of Benefits

If you are covered by more than one medical plan, it is possible the other plan will pay a benefit that this Plan should have paid. If this occurs, the Plan may pay the other plan the amount it should have paid.

If the Plan pays you more than it should under this COB section, you should promptly return the overpayment amount. Otherwise, ERS may recover the overpayment by deducting from future Benefits or by taking other legal action.

If the Plan overpays a health care Provider, the Plan may recover the excess amount from the Provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays Benefits to or on behalf of a Participant, that Participant, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Participant, but all or some of the expenses were not paid by the Participant or were not legally required to be paid by the Participant;
- all or part of the Plan's payment exceeded the allowed Benefits under the Plan; or
- all or part of the Plan's payment was made in error.

The amount that must be refunded to the Plan equals the amount the Plan paid in excess of the amount that the Plan should have paid under the Plan. If the refund is due from another person or organization, the Participant agrees to assist the Plan in obtaining the refund if requested.

If the Participant, or any other paid person or organization, does not promptly refund the full amount, ERS may reduce the amount of any future Benefits for the Participant that are payable under the Plan. The reductions will equal the required refund amount.

Alternatively, ERS may impose one or more sanctions against the involved Participant(s) under Section 1551.351, Texas Insurance Code.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

What this section includes

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

The Plan has the right to recover Benefits it has paid on the Participant's behalf that were:

- made in error;
- due to a mistake in fact;
- incorrectly paid by the Plan during the time period of meeting the Deductible for the Calendar Year; or
- incorrectly paid by the Plan during the time period of meeting any Out-of-Pocket Maximum for the Calendar Year.

Benefits paid because the Participant misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for the Participant that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future Benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan incorrectly pays Benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting any Out-of-Pocket Maximum for the Calendar Year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that the Participant may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is or may be considered responsible. Subrogation applies when the Plan has paid to or on behalf of the Participant Benefits for a Sickness or Injury for which a third party is or may be considered responsible, e.g., a third party's insurance carrier if the Participant is involved in an auto accident with a third party.

To the maximum extent allowed by Texas law, the Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for any Benefits the Plan has paid to or on behalf of the Participant relating to any Sickness or Injury for which any third party is or may be responsible.

Right to Reimbursement

The right to reimbursement means that if a third party is or may be responsible to pay for the Participant's Sickness or Injury for which the Participant receives a settlement, judgment, or other recovery from any third party, the Participant must use those proceeds to return to the Plan, to the maximum extent allowed by Texas law, Benefits the Participant received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused the Participant to suffer a Sickness, Injury or medical damages, or who is legally responsible to pay for the Sickness, Injury or medical damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or medical damages; or
- any other persons or entities who are responsible for paying losses caused by the Participant's Sickness or Injury when such payments are subject to subrogation under Texas law.

Subrogation and Reimbursement Provisions

As a Participant, you agree to the following:

- up to the maximum amount allowed by Texas law, the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, to the extent allowed by law, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including, but not limited to, Hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from an allegedly responsible third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized and whether or not the third party disclaims liability. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, and no amount of associated costs, including, but not limited to, attorneys' fees and out-of-pocket expenses shall be deducted from the Plan's recovery without the Plan's express written consent, except as required by Texas law. No so-called equitable or common law, "Made-Whole Doctrine," "Fund Doctrine," or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat or limit this right.
- regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) arbitration, judgment or other monetary award, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights that are allowed under Texas law.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
    - complying with the terms of this section;

  - providing any relevant information requested;
  - signing and/or delivering such documents as the Plan or its administering firm reasonably request to secure the subrogation and reimbursement claim;
  - notifying the Plan, in writing, of any potential legal claim(s) you may have against any and all third parties for acts which caused Benefits to be paid or become payable;
  - responding promptly to requests for information about any accident or injuries;
  - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent or its administering firm's consent before releasing any party from liability or payment of medical expenses.

- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it under Texas law, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you to the maximum extent allowed by Texas law.
- you may not accept any settlement that does not fully reimburse the Plan to the maximum extent allowed by Texas law, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has paid for a Sickness or Injury allegedly caused by a third party or for which a third party is legally responsible to pay for your Sickness or Injury.
- the Plan's rights to recovery will not be reduced due to your own comparative negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including, but not limited to, filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- the provisions of this section also apply to the Participant's spouse, parents, guardian, or other representative of a Dependent child or Dependent spouse who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- the Participant's spouse and the Dependent's spouse are jointly and severally liable for the Plan's subrogation and reimbursement rights herein.
- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate; your surviving spouse, parents, and children; and your heirs or beneficiaries.
- your failure to cooperate with the Plan or its agents is considered a violation of the Plan. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Participant.

- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- subject to ERS' oversight and control, the Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.
- no allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100 percent of its interest allowed under Texas law unless the Plan provides written consent to the allocation.
- BCBSTX does not have the authority to accept any negotiable instrument or any payment containing any terms or conditions that differ from or adds to the terms and conditions in this MBPD or the terms and conditions previously accepted in a Mutual Release and Settlement Agreement.

The retention, cashing, or depositing by BCBSTX of a negotiable instrument, such as a check, with any additional or different terms or conditions or a restrictive endorsement shall not be considered a discharge of the Participant's existing obligations nor an acceptance of an offer by BCBSTX or ERS. Such action on the part of BCBSTX shall not create a new contract between the parties nor constitute an accord and satisfaction of the obligations. Moreover, such action shall not create an alteration or modification of the terms and conditions of the Plan or the MBPD. BCBSTX and ERS retain the right to pursue the totality of the amount due.

As a Participant in the Plan, you are obligated under the terms of the MBPD to cooperate with the Plan to protect its subrogation rights and not prejudice the Plan's right of recovery and reimbursement.

As used in this Section 10, "Texas law" includes, but is not limited to, Texas Civil Practices and Remedies Code, Chapter 140.

Note: The subrogation rights and obligations under the Plan shall be governed by Texas law regardless of where the Participant resides or whether the Injury occurs in or outside the state of Texas.

Example
You are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. If you subsequently file a lawsuit against the insurer of the person who caused the accident and receive a settlement or receive payment from the insurer without filing suit, the Plan is entitled to direct payment from you for the Benefits the Plan paid.

SECTION 11 - WHEN COVERAGE ENDS

What this section includes

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Your eligibility for Benefits automatically ends on the date that your coverage ends. When your coverage ends, the Plan will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after your coverage ended, even if the underlying condition occurred before your coverage ended, you are hospitalized, or are otherwise receiving medical treatment.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with your Employer ends;
- the last day of the month your contributions were paid in full if you stop making the required contributions;
- the last day of the month you are no longer eligible for coverage;
- the last day of the month that BCBSTX receives written notice from ERS to end your coverage, or the date specified in the notice;
- the last day of the month you retire, unless you are eligible for other coverage as a Retiree; or
- the effective date you are expelled from the Plan as provided under Chapter 1551, Texas Insurance Code.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month your contributions were paid in full if you stop making the required contributions;
- the last day of the month that BCBSTX receives written notice from ERS to end your coverage, or the date specified in the notice;
- the last day of the month your Dependents become ineligible as Dependents under this Plan; or
- the effective date you are expelled from the Plan as provided under Chapter 1551, Texas Insurance Code.

Extended Coverage

Coverage for a Disabled Child

While you are a Subscriber under this Plan, if an enrolled Dependent child with a mental or physical disability reaches 26 years of age, the Plan will continue to cover the Dependent child, as long as the Dependent child is mentally or physically incapacitated to such an extent that he or she is dependent upon you for care or support.

You must apply with ERS to continue Benefits before the first day of the month following the Dependent child's 26th birthday. If an extension of coverage is temporarily approved, you must reapply with ERS for an additional extension of coverage for the Dependent child before the prior temporary extension approval's expiration date.

If you have a disabled Dependent child who was not covered at the time they turned age 26, or if your Dependent child becomes disabled after they turned age 26, you may apply for coverage for them during your next Annual Enrollment period or within the first 30 days from the date of your Dependent child's first medical treatment related to his or her disability.

As a new Employee, you may apply for coverage for a disabled Dependent child aged 26 and over during your initial enrollment period as a new Employee.

Coverage for a Dependent child past age 26 is not guaranteed and is subject to approval by ERS.

COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in Section 13, *Glossary*.

Much of the language in this section comes from the federal law that governs continuation coverage under COBRA. You should call ERS if you have questions about your right to continue coverage under COBRA.

In order to be eligible for continuation coverage under COBRA, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Subscriber;
- a Subscriber's covered Dependent; or
- a Subscriber's covered spouse upon divorce.

Qualifying Events for Continuation Coverage under COBRA

Table 11 describes situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are qualifying events, for purposes of continuation of coverage under COBRA.

TABLE 11			
If Coverage Ends Because of the Following Qualifying Events:	**You May Elect continuation coverage under COBRA for up to the following maximum periods:**		
	For Yourself	**For Your Spouse**	**For Your Child(ren)**
Your work hours are reduced[1]	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your Dependent becomes eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[2]	Up to 29 months	Up to 29 months	Up to 29 months
You die	N/A	36 months	36 months
You divorce	N/A	36 months	36 months[3]
Your child is no longer an eligible Dependent (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See Table 12	See Table 12

[1]This can be a qualifying event under COBRA only for Employees of Institutions of Higher Education covered under the Plan. The specific Institution of Higher Education determines the number of hours in a month an Employee must work to be eligible for coverage under the Plan. When the number of hours is decreased so that the Employee is not eligible for coverage under the Plan, then this a qualifying event under COBRA.

[2]Subject to the following conditions: (i) the Qualified Beneficiary must give ERS notice of the disability not later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided to ERS within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[3]This period applies to children who lose coverage due to the divorce. If the former spouse's children were covered under the Plan, they will lose coverage and may elect continuation coverage under COBRA. The COBRA election does not apply to the Subscriber's children who continue to be eligible for coverage as the Subscriber's Dependents.

Note: While some Qualifying Life Events as described in Section 2, *Introduction*, are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed in that section.

How Your Medicare Eligibility Affects Dependent Continuation Coverage Under COBRA

Table 12 below describes how your Dependents' continuation of coverage under COBRA is impacted if you become eligible for Medicare.

TABLE 12	
If Dependent Coverage Ends When:	**Your Dependent May Elect Continuation Coverage Under COBRA For Up To:**
You become eligible for Medicare and don't experience any additional qualifying events	36 months
You become eligible for Medicare, after which you experience a second qualifying event[1] before the initial 18-month period expires	36 months
You experience a qualifying event[1], after which you become eligible for Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare eligibility would have resulted in loss of Dependent coverage under the Plan	36 months

[1]For example, your employment is terminated for reasons other than gross misconduct.

Getting Started

ERS will notify you by mail if you become eligible for continuation coverage under COBRA. The notification will give you instructions for electing continuation coverage under COBRA and advise you of the monthly cost. Your monthly cost is the full cost, including both Subscriber and Dependent costs, if applicable, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 105 days from the date you receive notification or from the date your coverage ends, whichever is later, to elect and pay the cost of your continuation coverage under COBRA. The payment must include the monthly cost for all months retroactive to the date your Plan coverage ended.

During the 105-day election period, the Plan will, only if you request, inform the Provider of your right to elect continuation coverage under COBRA, retroactive to the date your COBRA eligibility began.

While you are a Participant in the Plan under COBRA, you have the right to change your coverage election:

- during Annual Enrollment; and
- following a Qualifying Life Event, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce or loss of Dependent status, you or your Dependents must notify ERS or your Benefit Coordinator within 60 days of the latest of:

- the date of the divorce or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify ERS when a secondary qualifying event occurs that will extend continuation coverage under COBRA.

If you or your Dependents fail to notify ERS of these events within the 60-day period, the Plan is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under COBRA, you must also notify ERS within 31 days of any Qualifying Life Event.

Once you have notified ERS, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA continuation coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide ERS with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to ERS at the address stated in Section 14, *Important Administrative Information*. The contents of the notice must be such that ERS is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA continuation coverage election period for certain Subscribers who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA continuation coverage election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA continuation coverage for themselves and certain family members (if they did not already elect COBRA continuation coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after his/her group health plan coverage ended.

If a Subscriber qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact ERS for additional information. The Subscriber must contact ERS promptly after qualifying for assistance under the Trade Act of 1974 or the Subscriber will lose his or her special COBRA rights. COBRA continuation coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost but begins on the first day of the special second election period.

When Continuation Coverage Under COBRA Ends

COBRA continuation coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the required premium payment; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

***Note*:** If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A Subscriber who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Subscriber and the Subscriber's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Subscribers may elect to continue coverage under the Plan by notifying their Employer in advance and providing payment of any required contribution for the health coverage. This may include the amount the Employer normally pays on a Subscriber's behalf. If a Subscriber's Military Service is for a period of time less than 31 days, the Subscriber may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Subscriber may continue Plan coverage under USERRA for up to the lesser of:

- the 24-month period beginning on the date of the Subscriber's absence from work; or
- the day after the date on which the Subscriber fails to apply for, or return to, a position of employment.

Regardless of whether a Subscriber continues health coverage, if the Subscriber returns to a position of employment that is eligible for participation in the GBP, the Subscriber's health coverage and that of the Subscriber's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Subscriber or the Subscriber's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call your Benefits Coordinator if you have questions about your rights to continue health coverage under USERRA.

SECTION 12 - OTHER IMPORTANT INFORMATION

What this section includes

- Qualified Medical Child Support Orders;
- Your relationship with BCBSTX and the Employees Retirement System of Texas;
- Relationships between Providers, BCBSTX and HealthSelect;
- Interpretation of the Plan;
- Records; and
- How to access the Master Benefit Plan Document.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical Benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a National Medical Support Notice for your child that instructs the Plan to cover the child, your Benefits Coordinator will review it to determine if it meets the requirements for a QMCSO. If it is determined that it does, and your child meets the definition of an eligible Dependent, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as provided under the Plan.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with Blue Cross and Blue Shield of Texas and the Employees Retirement System of Texas

In order to make choices about your health care coverage and treatment, it is important you understand how BCBSTX interacts with the Plan and how it may affect you. The ERS Board of Trustees has contracted with BCBSTX as a third-party administrator of the Plan to assist in the administration of the Plan. Neither ERS nor BCBSTX provides medical services or makes treatment decisions.

BCBSTX processes claims for Benefits and communicates with you regarding decisions about whether the Plan will cover the health care that you may receive. The Plan pays for Covered Health Services, which are more fully described in this MBPD.

BCBSTX is not an employer or employee of ERS for any purpose with respect to the administration or provision of Benefits under this Plan.

Relationships between Network Providers, Blue Cross and Blue Shield of Texas and HealthSelect

The relationships between BCBSTX and Network Providers are solely contractual relationships between independent contractors. Network Providers are not agents or employees of ERS, HealthSelect or BCBSTX. ERS and its employees are not agents or employees of Network Providers, nor are BCBSTX and its employees' agents or employees of Network Providers.

BCBSTX arranges for health care Providers to participate in the HealthSelect Network and administers the HealthSelect Plan, on behalf of ERS subject to ERS' oversight. Network Providers are independent practitioners who run their own offices and Facilities. BCBSTX' credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided. ERS and BCBSTX do not have any other relationship with Network Providers. ERS and BCBSTX are not liable for any act or omission of any Provider in caring for any Participant receiving health care services covered under the Plan.

Your Relationship with Providers

The relationship between you and any Provider is that of Provider and patient. Your Provider is solely responsible for the quality of the health care goods and services provided to you. You are responsible for:

- choosing your own Provider;
- paying, directly to your Provider, any amount identified as a Participant's responsibility, including Copays, Coinsurance, any Annual Non-Network Deductible, other deductibles and any amount a Non-Network Provider charges that exceeds Allowable Amounts;
- paying, directly to your Provider, the cost of any health care service not covered by the Plan;
- deciding if each Provider treating you is right for you (this includes Network and Non-Network Providers you choose as well as Providers to whom you have been referred); and
- deciding with your Provider what care you should receive, even if it is not covered under the Plan.

Interpretation of the Plan

ERS has discretion to interpret Plan provisions including this MBPD and any Amendment or Addendum.

ERS has delegated to BCBSTX the discretion to determine whether a treatment or supply is a Covered Health Service and how the Allowable Amounts will be determined and otherwise covered under the Plan, according to guidelines established by the Plan and/or BCBSTX.

In certain circumstances, for purposes of overall cost savings or efficiency, ERS, in its discretion, may approve Benefits for services that would otherwise not be Covered Health Services. The fact that ERS does so in any particular case shall not in any way be deemed to require ERS to do so in other similar cases.

Records

All Participant records that are in the custody of ERS or BCBSTX are confidential and not subject to public disclosure under Chapter 552, Texas Government Code, Section 1551.063, Texas Insurance Code, and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For complete listings of your medical records or billing statements, BCBSTX recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms. If you request medical forms or records from BCBSTX, it also may charge you reasonable fees to cover costs for completing the forms or providing the records.

How to Access the Master Benefit Plan Document

You can find copies of your MBPD and any future Amendments at **healthselectoftexas.com** or you may request printed copies by contacting BCBSTX at (800) 252-8039 (TTY: 711).

SECTION 13 - GLOSSARY

What this section includes

- Definitions of terms used throughout this Master Benefit Plan Document (MBPD).

Many of the terms used throughout this MBPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this MBPD, but it does not describe the Benefits provided by the Plan.

ABA – see Applied Behavior Analysis (ABA)

Act – the Texas Employees Group Benefits Act (Texas Insurance Code, Chapter 1551).

Actively at Work, Actively Working, Active Work, Active Service or Active Duty – the active expenditure of time and energy in the service of the Employer, including elected officials of the State who are eligible for coverage under the Act. An Employee will be considered to be on Active Duty on each day of a regular paid vacation or regular paid sick leave, or on a regular non-working day, provided he was Actively at Work on the last preceding workday.

Addendum – an attached written description of additional or revised provisions to the Plan. The Benefits and exclusions of this Master Benefit Plan Document and any Amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Master Benefit Plan Document and/or Amendments to the Master Benefit Plan Document, the Addendum shall be controlling.

Airrosti Rehab Center – a Facility that provides Chiropractic Treatment to Participants not enrolled in Medicare by using applied integration for the rapid recovery of soft tissue.

Allowable Amounts – the maximum amounts, determined by BCBSTX, that the Plan could pay for Benefits for Covered Health Services while the Plan is in effect.

Allowable Amounts determinations are subject to BCBSTX' reimbursement policy guidelines. BCBSTX develops the reimbursement policy guidelines, in BCBSTX' discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS);
- as reported by generally recognized professionals or publications;
- as used for Medicare; or
- as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that BCBSTX accepts.

Alternate Facility – a health care Facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- surgical services;
- Emergency Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an Outpatient basis or Inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the Amendment specifically changes.

Annual Enrollment – the period of time during which eligible Subscribers may enroll themselves and their eligible Dependents in the Plan. ERS determines the period of time that is the Annual Enrollment period.

Annual Non-Network Deductible (or Non-Network Deductible) – the amount you must pay for Covered Health Services in a Calendar Year before the Plan will begin paying Non-Network Benefits in that Calendar Year. The Non-Network Deductibles are shown in Table 2 in Section 5*, Schedule of Benefits and Coverage*.

Applied Behavior Analysis (ABA) – Intensive Behavioral Therapy, generally given or supervised by a Board-Certified Behavior Analyst (BCBA), which consists of a series of behavioral and/or habilitative interventions for the treatment of Autism Spectrum Disorders.

Applied Behavior Analysis (ABA) Provider – a Mental Health Provider who has advanced training in developmental disorders and ABA at the master's or higher level and is certified as a Board-Certified Behavior Analyst (BCBA) by the Behavior Analyst Certification board, or an appropriately trained and qualified paraprofessional directly supervised by the above. If the state where services are provided licenses ABA professionals, the state licensure is required in addition to the above.

Authorized Representative – a person authorized to act on behalf of a Participant. This does not include a Provider or other entity acting as an assignee of a Participant's claim. See *Authorized Representative* in Section 8, *Claims Procedures*, for information on how to properly designate an Authorized Representative. An Authorized Representative must be properly designated in order to protect against improper disclosure of information about a Participant including protected health or other confidential information.

Autism Spectrum Disorders – a neurodevelopmental disorder marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Balance Billing – the difference between the Non-Network Allowable Amount and the amount billed by a Non-Network Provider. This difference can be billed by a Non-Contracted Provider. - See Surprise Billing

Bariatric Deductible – the amount an Employee must pay for Bariatric Surgery before he or she is eligible to begin receiving Network Benefits for such surgery. Benefits are not paid for Bariatric Surgery provided by a Non-Network Provider. The separate Bariatric Deductible is shown in Table 3 in Section 5*, Schedule of Benefits and Coverage*, under *Bariatric Surgery*.

Bariatric Surgery – is the surgical treatment of morbid obesity and includes the gastric bypass procedure as one of several classes of operations.

BCBSTX – see Blue Cross and Blue Shield of Texas (BCBSTX)

Behavioral Health Practitioner – means a Physician or Professional, appropriately licensed Other Provider who renders services for the treatment of Mental Illness, or Substance Use Disorder, only as listed throughout MBPD.

Benefits – Plan payments for Covered Health Services, subject to the Act, the Patient Protection and Affordable Care Act (ACA), the Rules of the ERS Board of Trustees, the terms and conditions of the Plan and any Addendums and/or Amendments.

Benefits Coordinator – a person employed by your Employer to provide assistance for Participants with various benefit programs, including the Plan. ERS is the Benefits Coordinator for Retirees.

BlueCard® Program – a Blue Cross Blue Shield Association program that allows Participants to access care while traveling within the United States and its territories.

Blue Cross Blue Shield Global® Core – a Blue Cross Blue Shield Association program that allows Participants to access limited care while traveling outside the United States and its territories.

Blue Cross and Blue Shield of Texas (BCBSTX) – the Plan's third-party administrator and the company that, with its affiliates, provides certain services and claim administration services for the Plan on behalf of the Plan Administrator.

Blue Distinction Center - a Facility that has entered into an agreement with BCBSTX to provide Covered Health Services for the treatment of specific diseases or conditions.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Calendar Year – the annual period of time from January 1 to December 31, inclusive, as distinguished from Plan Year, which is from September 1 through August 31, inclusive.

CHD – see Congenital Heart Disease (CHD).

Chiropractic Treatment – the therapeutic application of chiropractic treatment and/or manipulative treatment with or without ancillary physical therapy and/or rehabilitative methods rendered to restore or improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Claim Administrator – means BCBSTX, a division of Health Care Service Corporation and the Plan's third-party administrator, when providing claims administration.

Clinical Trial – A research study in which one or more human subjects are prospectively assigned to one or more interventions (which may include placebo or other control) to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Allowable Amounts you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*. The percentage of Allowable Amounts paid by the Plan for Covered Health Services is shown in Table 3 in Section 5, *Schedule of Benefits and Coverage*.

Complications of Pregnancy – complications (when Pregnancy is not terminated) for which diagnoses are distinct from Pregnancy but adversely affected or caused by Pregnancy, such as nephritis, cardiac decompensation and miscarriage. It does not include false labor, occasional spotting, Physician prescribed rest during Pregnancy, morning Sickness, hyperemesis gravidarum, preeclampsia, eclampsia, and similar conditions associated with Pregnancy not constituting a nosologically distinct complication of Pregnancy. Covered Health Services for Complications of Pregnancy do not include services and supplies provided at termination of Pregnancy.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months after birth.

Congenital Heart Disease (CHD) – any structural heart condition or abnormality that has been present since birth. Congenital Heart Disease may:

- be passed from a parent to a child (inherited);
- develop in the unborn child of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage at the insured's expense to certain Employees and their Dependents whose group health insurance has been terminated.

Continuity of Care – ensures Continuing Care Patients are able to continue to receive care from their Provider for a period of time when their Provider in no longer in the Plan Network. See also Continuing Care Patient.

Continuing Care Patient – meets one or more of qualifying conditions with respect to a Provider or Facility that is no longer in the Plan's Network as described *in Addendum - Continuity of Care.*

Contracted Provider – a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a Provider.

Copay – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Plan. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in a function, e.g., breathing.

Cost-Effective – the least expensive item or service that performs the necessary function. This term applies to Durable Medical Equipment, prosthetic devices and certain other Covered Health Services.

Covered Health Services – those health services, supplies and Medications and Injections, which the Plan determines to be:

- Medically Necessary;
- included in Sections 5 and 6, *Schedule of Benefits and Coverage* and *Details for Covered Health Services*, described as a Covered Health Service;
- provided to a Participant who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 7, *Exclusions*: *What the Medical Plan Will Not Cover*, as not covered.

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including, but not limited to, feeding or cooking, dressing, going to the toilet, preventive and pain-relieving skin care, bathing, ostomy care, incontinence care, checking of routine vital signs and ambulating or exercising functions);
- are provided for the primary purpose of meeting the personal needs of the Participant or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Declaration of Informal Marriage – a document that memorializes that a man and a woman desire to consider themselves married for all legal purposes. The completed document requires the notarized signatures of both parties and must be filed with the District Clerk of the county of the couple's residence.

Deductible – see Annual Non-Network Deductible (or Non-Network Deductible).

Dependent – an individual who, because of a statutorily defined relationship with a Subscriber, meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*, and is enrolled as a Participant in the Plan. A Dependent does not include anyone who is enrolled in the Plan as a Subscriber. No one can be enrolled as a Dependent of more than one Subscriber.

Developmental Delay – a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- cognitive development;
- physical development;
- communication development;
- social or emotional development; or
- adaptive development.

DME – see Durable Medical Equipment (DME).

Domiciliary Care – a supervised living arrangement in a home-like environment, providing assistance with activities of daily living, for Participants who are unable to live independently because of age-related impairments or physical, mental or visual disabilities.

Durable Medical Equipment (DME) – any medical equipment appropriate for use in the home to aid in a better quality of living for Participants with a Sickness, Injury or disability, and that meets the requirements specified under *Durable Medical Equipment (DME)* in Section 6, *Details for Covered Health Services*.

Educational – services, supplies, and related expenses provided to address a Participant's Developmental Delays, or otherwise provide training, skills, practice and exercises designed to enhance academic performance, to teach positive behaviors and/or discourage inappropriate, destructive or otherwise negative conduct. It includes, but is not limited to, special education or conventional learning techniques, operant conditioning or other forms of training.

Emergency Condition – a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Emergency Department – includes a hospital outpatient department that provides Emergency Services. – see Emergency Services.

Emergency Medical Services Provider - a person who uses or maintains emergency medical services vehicles, medical equipment, and emergency medical services personnel to provide emergency medical services as defined in Texas Health and Safety Code Sec.773.003, except air ambulance services.

Emergency Services – services provided in a Hospital Emergency Facility, freestanding emergency care Facility, or comparable Facility to evaluate and stabilize conditions of a recent onset and severity (regardless of the department of the facility in which treatment is provided), including but not limited to severe pain, that would lead a Prudent Layperson, possessing an average knowledge of medicine and health, to believe that their condition, sickness or Injury is of such a nature that failure to get immediate care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment of a bodily function;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the unborn child.

Employee – an appointive or elective state officer (including a judicial officer) or employee in the service of the state of Texas, including an employee of an Institution of Higher Education, as defined in Section 1551.003 of the Act and in this *Glossary*, and any persons required or permitted by the Act to enroll as Subscribers. Eligibility for participation in the Plan for Employees is limited to the specific statutes that include them as Employees. This definition does not infer any greater eligibility for or right of access to the Benefits provided by this Plan than the statutes establishing each class of eligible persons.

Employer – the state of Texas and all its agencies, certain political subdivisions or Institutions of Higher Education, as defined in this *Glossary*, that employ or employed a Subscriber.

End-Stage Renal Disease (ESRD) –a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. Beneficiaries may become entitled to Medicare based on ESRD.

EOB – see Explanation of Benefits (EOB).

ESRD – see End-Stage Renal Disease (ESRD).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric mental health, substance-related and addictive disorder or other health care services, technologies, supplies, treatments, procedures, drug or other therapies, medications or devices that, at the time the Plan makes a determination regarding coverage in a particular case, the Plan determines to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Routine Patient Care Costs for Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Details for Covered Health Services*.

- If you have a significantly life-threatening Sickness, Injury or other condition, ERS, or BCBSTX as its designee, may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness, Injury or other condition. Prior to such a consideration, the Plan must first establish, based on good faith medical judgment supported by sufficient scientific evidence that although Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for that Sickness, Injury or other condition.
- In making its determination, ERS, or BCBSTX as its designee, will refer to a certification the Participant's Physician must provide stating that he or she, based on good-faith medical judgment, believes:
    - the Sickness, Injury or other condition is significantly life threatening and imminently fatal if the treatment is limited to Covered Health Services; and
    - although designated as Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for the Sickness, Illness or condition.
- In addition to clinical studies regarding the Experimental or Investigational Service, the Plan may consider scientifically grounded standards based on Physician specialty society recommendations and professional standards of care. The Plan reserves the right to obtain expert opinion(s) in determining whether an otherwise Experimental or Investigational Service shall be considered as a Covered Health Service for a particular Sickness, Injury or other condition. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Plan's sole discretion.

Appeals from a BCBSTX pre-service decision not to consider the Experimental or Investigational Service to be a Covered Health Service will be handled as an appeal of an Urgent Request for Benefits under Section 8, *Claims Procedures* of this MBPD.

Explanation of Benefits (EOB) – a statement provided by BCBSTX to you, your Physician, or another health care professional regarding a specific claim for health services or supplies that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance and Copays;
- any other reductions;
- the net amount paid by the Plan;
- the amount that is your responsibility (the amount you may owe your Provider); and
- the reason(s) why the service or supply was not covered by the Plan.

Facility – a Hospital, Alternate Facility, Inpatient Rehabilitation Facility, Freestanding Emergency Room, Freestanding Emergency Department, Skilled Nursing Facility, Residential Treatment Facility or Urgent Care Center (all as defined in this *Glossary*) or other institution that is licensed to provide services and supplies covered by the Plan and that is approved by BCBSTX. Other Facilities include, but are not limited to:

- ambulatory surgical center;
- birthing centers;
- Hospice;
- imaging centers;

- independent laboratories;
- psychiatric day treatment facilities, such as Partial Hospitalization Program (PHP) or Intensive Outpatient Program (IOP);
- radiation therapy centers; and
- renal dialysis centers;
- Substance-related and addictive disorder treatment facilities

In states where there is a licensure requirement, other Facilities similar or equivalent to the above must be licensed by the appropriate state administrative agency.

Facility-Based Provider/Physician – a Physician, Health Care Practitioner, or other health care Provider who provides health care or medical services to patients of a Hospital Facility. This includes, but is not limited to, emergency care Physicians, consulting Physicians, assistant surgeons, Durable Medical Equipment Providers, surgical assistants, laboratory technicians, radiologists, anesthesiologists and pathologists.

Former COBRA Unmarried Child – A child of an Employee or Retiree who is unmarried; whose GBP coverage as a Dependent has ceased; and who upon expiration of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272 (COBRA) reinstates GBP coverage.

Freestanding Emergency Department –Facility that provides Emergency Services that is affiliated with a Hospital but that is not physically connected to a Hospital (i.e., structurally separate and distinct).

Freestanding Emergency Room – an independent health care Facility that provides Emergency Services that is **not** affiliated with a Hospital and is not physically connected to a Hospital (i.e., structurally separate and distinct).

GBP – see Group Benefits Program (GBP or the Program).

Genetic Testing – examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Group Benefits Program (GBP or the Program) – the Texas Employees Group Benefits Program as established by the Act and administered by the Employees Retirement System of Texas and its Board of Trustees pursuant to the Act.

Habilitation – a process aimed at helping people attain, keep or improve skills and functioning for daily living, including, but not limited to physical, occupational, and speech-language therapy.

HealthSelect of Texas® Plan or HealthSelect – a self-funded health benefit plan offered by ERS through the Texas Employees Group Benefits Program. It includes an In-Area Plan, a HealthSelect℠ Out-of-State Plan, a high deductible health plan that is part of Consumer Directed HealthSelect℠, a HealthSelect℠ Secondary Plan, and a Prescription Drug Program.

HealthSelectShoppERS℠ – a program available to active Employees and their Dependents who are also Participants covered under the HealthSelect of Texas In-Area, HealthSelect Out-of-State and Consumer Directed HealthSelect Plans, where eligible Participants can save money and Subscribers earn incentives when shopping for and choosing lower cost Facilities for certain medical services. Refer to *Addendum – Resources to Help You Stay Healthy*, for details about the program.

Home Health Agency – a program or organization authorized by law to provide health care services in the home and certified by Medicare as a supplier of home health care.

Hospice – a Facility or agency primarily engaged in providing Hospice care as described in Section 6, *Details for Covered Health Services*, licensed under state law, and certified by Medicare as a supplier of Hospice care.

Hospital – an institution, operated as required by law, that is:

- primarily engaged in providing health care services, on an Inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorder, diagnostic and surgical Facilities, by or under the supervision of a staff of Physicians; and
- has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care, Domiciliary Care or care of the aged and it is not a Skilled Nursing Facility, convalescent home or similar institution.

Individualized Family Service Plan – an initial and ongoing treatment plan for Developmental Delay of eligible children up to age 3.

Injury – bodily damage other than Sickness or disability, including all related conditions and recurrent symptoms.

Inpatient – a Participant who has been admitted to a Hospital, Nursing Facility or Inpatient Rehabilitation Facility or an Inpatient Facility for Mental Health Services, or Substance Use Disorder Services.

Inpatient Copay Maximum – the most you are required to pay each Calendar Year in Copays for Inpatient Stays. There are separate Network and Non-Network Inpatient Copay Maximums for this Plan. The Inpatient Copay Maximum amount is shown in Table 2 in Section 5*, Schedule of Benefits and Coverage*. Refer to Section 3, *How the Plan Works*, for a description of how the Inpatient Copay Maximum works.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an Inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility or an Inpatient Care Facility for Mental Health Services or Substance Use Disorder Services.

Institution of Higher Education – a public junior college, a senior college or university, or any other agency of higher education within the meaning and jurisdiction of Chapter 61, Texas Education Code. It does not include an entity in The University of Texas System, as described in Section 65.02, Texas Education Code and an entity in The Texas A&M University System, as described in Subtitle D, Title 3, Texas Education Code, including the Texas Veterinary Medical Diagnostic Laboratory.

Intensive Behavioral Therapy – an umbrella term for a variety of Outpatient behavioral interventions that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age-appropriate skills in people with Autism Spectrum Disorder. The most common Intensive Behavioral Therapy is Applied Behavior Analysis (ABA).

Intensive Outpatient Program (IOP) – a structured Outpatient mental health or substance-related and addictive disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Skilled Nursing Care – skilled nursing care that is provided either for:

- fewer than seven days each week; or
- fewer than eight hours each day for a period of 21 days or less.

The Plan may make exceptions for special circumstances when the need for additional skilled nursing care is finite and predictable.

IOP – see Intensive Outpatient Program (IOP).

Medicaid – a federal program administered and operated individually by participating state and territorial governments and providing health care coverage to eligible low-income people.

Medical Supplies - expendable items required for care related to a Sickness or Injury. Not all Medical Supplies are Covered Health Services under the Plan. See *Medical Supplies* in Section 6, *Details for Covered Health Services* and *Medical Supplies and Equipment* in Section 7, *Exclusions: What the Medical Plan Will Not Cover*, for a description.

Medically Necessary, Medical Necessity – health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorder, or disease (and symptoms), that are all of the following as determined by the Plan. The health care services must be:

- performed in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorder, or disease (and symptoms);
- not primarily performed for your comfort or convenience or that of a health care Provider which provides non-medical care to assist with activities of daily living (referred to as custodial care); and
- not less effective or more resource intensive than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as alternatives with respect to the diagnosis or treatment of your Sickness, Injury, Mental Illness, substance-related and addictive disorder, or disease (and symptoms).

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled Clinical Trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the health care services and positive health outcomes.

If no credible scientific evidence is available, then standards based on Physician specialty society recommendations or professional standards of care may be considered. The Plan reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Plan's sole discretion.

BCBSTX develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific health services. These clinical policies (as developed by BCBSTX and revised from time to time), are available to Participants at **bcbstx.com** or by calling BCBSTX at (800) 252-8039 (TTY: 711), and to Physicians and other health care professionals at **bcbstx.com**.

The authority of the Plan to determine Medical Necessity is subject to the right of the Employees Retirement System of Texas Board of Trustees to order payment of a claim even though BCBSTX has not abused its discretion in denying the claim.

Medicare – Parts A, B, C and D of the insurance program for Americans 65 years of age and over as well as younger Americans with certain disabilities, established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Medicare-Approved Amount –the maximum amount Medicare pays a Provider that accepts Medicare Assignment. It may be less than the actual amount a Physician or supplier bills.

Medicare Assignment – means that your Provider agrees (or is required by law) to accept the Medicare-Approved Amount as full payment for services covered by Medicare.

Medicare Limiting Charge – if you are enrolled in Medicare, this is the maximum amount Medicare allows Providers who do not accept Medicare Assignment to bill Participants. Not all services are subject to the Medicare Limiting Charge, including supplies or equipment. For more information on the Medicare Limiting Charge, go to **Medicare.gov**.

Medicare Summary Notice (MSN) – a statement provided by Medicare to you, your Physician, or another health care professional regarding a specific claim for health services processed by Medicare and explains:

- the Benefits provided (if any);
- the Medicare-Approved Amounts;
- Deductibles;
- the net amount paid by Medicare;
- the amount you may owe your Provider; and
- the reason(s) why the service or supply was not covered by the Plan.

Medications and Injections – U.S. Food and Drug Administration (FDA)-approved prescription medication and injections administered in connection with a Covered Health Service by a Physician or other health care Provider within the scope of the Provider's license, and not otherwise excluded under the Plan. Medications and Injections do not include medications that are typically available by prescription order or refill at a pharmacy under the HealthSelect Prescription Drug Program (PDP).

Mental Health Provider - a Provider who is licensed to provide services and/or supplies for treatment of Mental Illness and acts within the scope of that license. Mental Health Providers include, but are not limited to:

- Doctor of Psychology (Psy.D. or Ph.D.) (certified as a health service Provider);
- psychiatrist (M.D. or D.O.);
- addictionologist (M.D. or D.O.);
- nurse-practitioner;
- Licensed Clinical Social Worker (LCSW) or Licensed Masters Social Worker – Advanced Practice (LMSW-AP);
- Licensed Marriage and Family Therapist (LMFT);
- licensed professional counselor;
- licensed dependency counselor;
- licensed psychological associate; and
- Applied Behavior Analysis (ABA) Provider.

Mental Health Providers must be licensed by the appropriate state administrative agency where the services are provided.

Mental Health Services – Covered Health Services performed for the diagnosis and treatment of Mental Illnesses, as described in Section 6, *Details for Covered Health Services*. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, or any other diagnostic coding system as used by the Plan, whether or not the cause of the disease, disorder or condition is

physical, chemical, or mental, in nature or origin, unless the service or diagnostic category is listed in Section 7, *Exclusions: What the Medical Plan Will Not Cover*.

Midwife - a Certified Nurse Midwife (CNM) who is an Advanced Practice Registered Nurse (APRN or APN), certified according to the requirements of the American Midwifery Certification Board (AMCB), acting within the scope of their license and under the supervision of a physician if required by law.

MSN – see Medicare Summary Notice (MSN).

Network – (sometimes referred to as HealthSelect Network) a nationwide system of Providers developed by BCBSTX or its affiliate to provide Covered Health Services to Participants in the Plan. Each Network Provider has a participation agreement in effect (either directly or indirectly) with BCBSTX or with its affiliate to participate in the Network. BCBSTX' affiliates are those entities affiliated with BCBSTX through common ownership or control with BCBSTX or with BCBSTX' ultimate corporate parent, including direct and indirect subsidiaries.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only certain products. In this case, the Provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and a Non-Network Provider for other Covered Health Services and products. The participation status of Providers may change from time to time.

You may find out the services for which a Provider is a Network Provider by calling BCBSTX at (800) 252-8039 (TTY: 711).

Network Benefits – Benefits that the Plan pays for Covered Health Services provided by Network Providers. Refer to Section 5, *Schedule of Benefits and Coverage*, for details about how Network Benefits apply.

Non-Contracted Provider – means a Hospital, Physician, Behavioral Health Practitioner, or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a Provider.

Non-Network – when used to describe a Provider of health care services, this means a Provider outside of the Network as established and maintained by BCBSTX.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by Non-Network Providers. Refer to Section 5, *Schedule of Benefits and Coverage*, for details about how Non-Network Benefits apply.

Non-Network Deductible – see Annual Non-Network Deductible (or Non-Network Deductible).

Other Provider - means a person or entity, other than a Hospital or Physician, that is appropriately licensed where required to provide to a Participant a service or supply described herein as Covered Health Services. Other Provider shall include:

1. **Facility Other Provider** - an institution or entity, only as listed:
    a. Chemical Dependency Treatment Center
    b. Crisis Stabilization Unit or Facility
    c. Durable Medical Equipment Provider
    d. Home Health Agency
    e. Home Infusion Therapy Provider
    f. Hospice
    g. Imaging Center
    h. Independent Laboratory

i. Prosthetics/Orthotics Provider
j. Psychiatric Day Treatment Facility
k. Renal Dialysis Center
l. Residential Treatment Facility for Children and Adolescents
m. Skilled Nursing Facility
n. Therapeutic Center

2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
   a. Advanced Practice Nurse
   b. Certified Nurse Midwife licensed as Advance Nurse Practitioner
   c. Doctor of Chiropractic
   d. Doctor of Dentistry
   e. Doctor of Optometry
   f. Doctor of Podiatry
   g. Doctor in Psychology
   h. Licensed Acupuncturist
   i. Licensed Audiologist
   j. Licensed Chemical Dependency Counselor
   k. Licensed Dietitian
   l. Licensed Hearing Instrument Fitter and Dispenser
   m. Licensed Marriage and Family Therapist
   n. Licensed Clinical Social Worker
   o. Licensed Occupational Therapist
   p. Licensed Physical Therapist
   q. Licensed Professional Counselor
   r. Licensed Speech-Language Pathologist
   s. Licensed Surgical Assistant
   t. Nurse Anesthetist
   u. Nurse First Assistant
   v. Physician Assistant
   w. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, Other Providers must be licensed by the appropriate state administrative agency.

Out-of-Pocket Coinsurance Maximum – the most you are required to pay each Calendar Year for Coinsurance. Refer to Section 5, *Schedule of Benefits and Coverage*, for the Out-of-Pocket Coinsurance Maximum amount. Refer to Section 3, *How the Plan Works*, for a description of how the Out-of-Pocket Coinsurance Maximum works.

Out-of-State – describes the part of the HealthSelect Plan that is available to Participants whose eligibility county is outside of Texas.

Outpatient – a Participant who has been treated at a Hospital or Facility for other than Inpatient treatment.

Outpatient Clinic Facility – a health care Facility that is not a Hospital or an Alternate Facility and that provides Physician's office services for Sickness or Injury on an Outpatient basis, as permitted by law.

Partial Hospitalization Program (PHP)/Day Treatment – a structured ambulatory program that may be free-standing or Hospital-based and that provides services for at least 20 hours per week.

Participant – an Employee, Retiree, or a Dependent, as defined in the Act, and surviving Dependents of deceased Employees and Retirees, or other persons eligible for coverage as provided under the Act while eligible for coverage and enrolled under the Plan. References to "you" and "your" throughout this Master Benefit Plan Document are references to a Participant.

Patient Protection and Affordable Care Act (ACA) – federal law that includes the Patient Protection and Affordable Care Act (Public Law 111-148; March 23, 2010; 124 Stat. 119) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152; March 30, 2010; 124 Stat. 1029), as amended. This is also referred to as the federal health care reform statute.

Personal Health Assistant (PHA) – a BCBSTX Personal Health Assistant provides customer service resources to help Participants navigate the health care system, including information on cost and quality transparency, RCR coordination, connection with clinical Educational resources and appointment scheduling.

PHA – see Personal Health Assistant (PHA).

PHP – see Partial Hospitalization Program (PHP)/Day Treatment.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law***. Please Note***: The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Plan.

Plan – the HealthSelect Out-of-State Plan.

Plan Administrator – the Employees Retirement System of Texas (ERS) or its designee.

Plan Service Area – the geographical area or areas designated by the Employees Retirement System of Texas Board of Trustees as the area that determines eligibility for the plan. See Section 2, *Introduction*, for more details.

Plan Year – The time period that begins on September 1 of each year and ends August 31 of the following year.

Post-Delivery Care – postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education;
- assistance and training in breast-feeding and bottle feeding; and
- the performance of any necessary and appropriate clinical tests.

Post-Stabilization Services – covered items and service that are furnished, regardless of the department, after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit where other emergency Services are furnished.

Post-Service Claim – a claim for Benefits that is not a Pre-Service Request for Benefits or Urgent Request for Benefits. Post-Service Claims include claims that involve only the payment or reimbursement of Allowable Amounts for Covered Health Services that have already been provided.

Pregnancy – includes, but is not limited to, prenatal care, postnatal care and childbirth. Complications of Pregnancy are considered separately as defined in this section.

Prescriber – any health care professional who is properly licensed and qualified by law to prescribe Prescription Drugs to humans and acts within the scope of that license. The fact that a Prescriber has prescribed a medication or product, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not make the product a Covered Drug under the Program.

Pre-Service Request for Benefits – a claim for Benefits where the Plan conditions receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining care.

Preventive Care – care that consists of measures taken for disease prevention, as opposed to diagnostic services or disease treatment.

Primary or Primary Plan – when you are covered by more than one health benefits plan, the Primary Plan is the plan that pays benefits first under coordination of benefits (COB) guidelines. Remaining Allowable Amounts may be paid under the other plan, which is called the Secondary Plan. Refer to Section 9, *Coordination of Benefits (COB)*, for details on COB guidelines.

Private Duty Nursing – shift or continuous nursing care that encompasses nursing services for Participants who require more individual and continuous care than is available from a visiting nurse through a Home Health Agency. Private Duty Nursing services are provided where longer durations of Skilled Care are required and may include shift care or continuous care 24 hours a day, 7 days a week in certain settings. Private Duty Nursing care is not care provided primarily for the comfort or convenience of the Participant.

Program – see Group Benefits Program (GBP or the Program).

Provider – a Facility, Hospital, Physician or Other Provider that is licensed to provide health care services and supplies and acts within the scope of that license and that is approved by BCBSTX.

Prudent Layperson - a person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate care to result in a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

QLE – see Qualifying Life Event (QLE).

Qualifying Life Event (QLE) – a life experience whose occurrence that allows a Participant to change health care coverage during a Plan Year, provided that the change in coverage is consistent with the life event. See *Changing Your Coverage* in Section 2, *Introduction*, for a list of Qualifying Life Events and how to change your coverage.

RCR – see Recommended Clinical Review (RCR).

Recommended Clinical Review (RCR) - an optional, voluntary pre-service review of a Provider's recommended medical procedure, treatment or test to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a condition or to improve or restore physiologic function.

Reconstructive Procedures include, but are not limited to, surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary intended result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the condition does not classify surgery or any other procedure done to relieve the condition as a Reconstructive Procedure.

Residential Treatment Facility – a Facility that provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;

- it provides a program of treatment under the active participation and direction of a Physician and approved by BCBSTX;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured group setting:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retail Health Clinic – health care clinic often located in a retail setting such as a supermarket or pharmacy, that provides treatment of common illnesses and routine Preventive Care services that can be rendered by appropriately licensed Providers located in the clinic.

Retiree – (also known as annuitant) an Employee who has retired as defined in the Act and, for purposes of Benefits under this Plan, is under the age of 65.

Routine Patient Care Costs – the costs of any Medically Necessary health care service for which Benefits are provided under the Plan, without regard to whether the Participant is participating in a clinical trial.

Routine patient care costs do not include:

- the investigational item, device, or service, itself;
- items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Second Opinion – an opinion from a second Provider or Other Provider as covered under this Plan. Applicable Benefits for all Covered Health Services will apply. For coverage details, see Section 5- *Schedule of Benefits and Coverage* and Section 6- *Details for Covered Health Services*.

Secondary or Secondary Plan – when you are covered by more than one health benefits plan, the Secondary Plan is the plan that pays benefits second, following the Primary Plan, under coordination of benefits (COB) guidelines. The Secondary Plan may or may not pay all remaining Allowable Amounts after the Primary Plan has paid, depending on how COB is determined. Refer to Section 9, *Coordination of Benefits (COB)*, for details on COB guidelines.

Semi-private Room – a room with two or more beds.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this MBPD includes Mental Illness and substance-related and addictive disorder, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care – skilled nursing, skilled teaching, and skilled rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the Participant;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;

- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing Facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist – (sometimes known as Specialist Physician) a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Specialty Drug – Prescription Drugs that are used in the treatment of rare or complex conditions and:

- may be administered by injection or infusion;
- may be high cost;
- have special delivery and storage requirements; and/or
- require close monitoring or care coordination by a pharmacist or Prescriber.

To find out whether a medication you're prescribed is considered a Specialty Drug, refer to the HealthSelect Prescription Drug Program (PDP) at **HealthSelectRx.com**. If you have questions about the Benefits that apply to Specialty Drugs under this medical Plan, call a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711).

State Agency – a commission, board, department, division, Institution of Higher Education, or other agency of the state of Texas created by the constitution or statutes of this state. This term also includes the Texas Municipal Retirement System, the Texas County and District Retirement System, the Teachers Retirement System and ERS.

Subscriber – the Participant who is the Employee, Retiree, or other person enrolled in the Plan as provided for under the Act, and who is not a Dependent.

Substance Use Disorder Services – (also referred to as chemical dependency services) Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorder that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* unless those services are specifically excluded by the Plan. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surprise Billing – is an unexpected Balance Billing that can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. – See Balance Bill.

Telemedicine – Certain services through use of a Provider-platform to provide health services through the use of interactive audio, video, other electronic media or advanced telecommunications technology. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. Telemedicine also includes 1) compressed digital interactive video, audio, or data transmission; 2) clinical data transmission using computer imaging by way of still image capture and store and forward; and 3) other technology that facilitates access to health care services or medical specialty expertise. Sometimes referred to as Telehealth. This is not the same as a Virtual Visit.

Tertiary or Tertiary Plan – when you are covered by more than one health benefits plan, the Tertiary Plan is the plan that pays benefits third, following both the Primary and Secondary Plans, under coordination of benefits (COB) guidelines. The Tertiary Plan may or may not pay all remaining Allowable Amounts after the Primary and Secondary Plans have paid, depending on how COB is determined. Refer to Section 9, *Coordination of Benefits (COB)*, for details on COB guidelines.

Total Network Out-of-Pocket Maximum – the most you are required to pay each Calendar Year for both Network Prescription Drug and Network medical benefits including: Annual Deductibles, Copays, and Coinsurance (medical benefits only), as detailed in Section 5, *Schedule of Benefits and Coverage*. Refer to Section 3, *How the Plan Works*, for a description of how the Total Network Out-of-Pocket Maximum works.

Unproven Services – health services, including medications, that have not been determined to be effective for treatment of the Sickness, Injury or other condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

BCBSTX has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, BCBSTX issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **bcbstx.com**.

Please Note: If you have a significantly life-threatening Sickness, Injury or other condition, ERS, or BCBSTX as its designee may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness, Injury or other condition. Prior to such a consideration, the Plan must first establish, based on good faith medical judgment supported by sufficient scientific evidence, that albeit unproven, the service has significant potential as an effective life-sustaining treatment for that Sickness, Injury or other condition.

In making its determination, ERS, or BCBSTX as its designee, will refer to a certification the Participant's Physician must provide stating that he or she, based on good-faith medical judgment, believes:

- the Sickness, Injury or other condition is significantly life threatening and imminently fatal if the treatment is limited to Covered Health Services; and
- although designated as Experimental or Investigational, the service has significant potential as an effective life-sustaining treatment for the Sickness, Illness or condition.

In addition to clinical studies regarding the Unproven Service, the Plan may consider scientifically grounded standards based on Physician specialty society recommendations and professional standards of care. The Plan reserves the right to obtain expert opinion(s) in determining whether an otherwise Unproven Service shall be considered as a Covered Health Service for a particular Sickness, Injury or other condition. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Plan's sole discretion.

Appeals from an ERS or BCBSTX decision not to consider the Experimental or Investigational Service to be a Covered Health Service will be handled as an appeal of an Urgent Request for Benefits under Section 8, *Claims Procedures* of this Master Benefit Plan Document.

Urgent Care – Health care services provided in a situation other than an emergency which are typically provided in a setting such as a physician or individual provider's office or Urgent Care Center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

Urgent Care Center – a Facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for a minor Sickness or Injury that occurs at night or on weekends; and
- provide an alternative to an emergency room if you need immediate medical attention, but your Physician cannot see you right away.

Urgent Request for Benefits – a claim for care or treatment with respect to which application of the time periods for making non-urgent determinations (a) could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or (b) in the opinion of the Participant's Physician, would subject the Participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

Virtual Network Provider – an appropriately licensed Provider that has entered into a contractual agreement with BCBSTX to provide diagnosis and treatment of injuries and illnesses through a Virtual Visit.

Virtual Visits – services provided by a Virtual Network Provider for the diagnosis and treatment of low acuity, non-emergency conditions through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology.

SECTION 14 – IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes
- Plan administrative information.

This section includes information on the administration of the Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Administrator: The Plan Administrator is the Employees Retirement System of Texas (ERS). ERS may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of administrative services including arrangement of access to a Network Provider; claims processing and payment services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This contracted administrator for the Plan is BCBSTX. For Benefits as described in this MBPD, ERS also has selected a Provider Network established by BCBSTX.

Employees Retirement System of Texas
200 East 18th Street
Austin, TX 78701
(877) 275-4377

ERS retains all fiduciary responsibilities with respect to the Plan except to the extent ERS has allocated to other persons or entities one or more fiduciary responsibility(s), as it has to BCBSTX, with respect to the Plan.

Blue Cross and Blue Shield of Texas: The company that provides certain administrative services for the Plan described in this MBPD.

Blue Cross and Blue Shield of Texas
P.O. Box 660044
Dallas, Texas 75266-0044

(800) 252-8039 (TTY: 711)

BCBSTX shall not be deemed or construed as an Employer for any purpose with respect to the administration or provision of Benefits under the Plan. BCBSTX shall not be responsible for fulfilling any duties or obligations of an Employer with respect to the Plan.

ATTACHMENT I – THE EMPLOYEES RETIREMENT SYSTEM OF TEXAS SUMMARY NOTICE OF PRIVACY PRACTICES

The Employees Retirement System of Texas ("ERS") administers the Texas Employees Group Benefits Program, including your health plan, as authorized by Chapter 1551 of the Texas Insurance Code. THIS NOTICE DESCRIBES HOW ERS MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU AND HOW YOU CAN GET ACCESS TO YOUR OWN INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA") PRIVACY RULE. PLEASE REVIEW THIS NOTICE CAREFULLY.

Uses and Disclosures of Health Information:

ERS and/or a third-party administrator under contract with ERS may use health information about you on behalf of your health plan to authorize treatment, to pay for treatment, and for other allowable health care purposes. Health care providers submit claims for payment for treatment that may be covered by the group health plan. Part of payment includes ascertaining the medical necessity of the treatment and the details of the treatment or service to determine if the group health plan is obligated to pay. Information may be shared by paper mail, electronic mail, fax, or other methods.

By law, ERS may use or disclose identifiable health information about you without your authorization for several reasons, including, subject to certain requirements, for public health purposes, for auditing purposes, for research studies, and for emergencies. ERS provides information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, ERS will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. ERS cannot use or disclose your genetic information for underwriting purposes. ERS may change its policies at any time. When ERS makes a significant change in its policies, ERS will change its notice and post the new notice on the ERS website at **ers.texas.gov**. Our full notice is available at **ers.texas.gov/pdfs/forms/hipaa-notice-of-privacy-practices-long-form**.

For more information about our privacy practices, contact the ERS Privacy Officer. ERS originally adopted its Notice of Privacy Practices and HIPAA Privacy Policies and Procedures Document April 14, 2003, and subsequently revised them effective February 17, 2010, and September 23, 2013.

Individual Rights:

In most cases, you have the right to look at or get a paper or electronic copy of health information about you that ERS uses to make decisions about you. If you request copies, we will charge you the normal copy fees that reflect the actual costs of producing the copies including such items as labor and materials. For all authorized or by law requests made by others, the requestor will be charged for production of medical records per ERS' schedule of charges. You also have the right to receive a list of instances when we have disclosed health information about you for reasons other than treatment, payment, healthcare operations, related administrative purposes, and when you explicitly authorized it. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that ERS correct the existing information or add the missing information. You have the right to request that ERS restrict the use and disclosure of your health information above what is required by law.

If ERS accepts your request for restricted use and disclosure, then ERS must abide by the request and may only reverse its position after you have been appropriately notified. You have the right to request an alternative means of communications with ERS. You are not required to explain why you want the alternative means of communication.

Complaints:

If you are concerned that ERS has violated your privacy rights, or you disagree with a decision ERS has made about access to your records, you may contact the ERS Privacy Officer. You also may send a written complaint to the U.S. Department of Health and Human Services. The ERS Privacy Officer can provide you with the appropriate address upon request.

Our Legal Duty:

ERS is required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this Notice, and obtain your acknowledgement of receipt of this Notice.

Detailed Notice of Privacy Practices:

For further details about your rights and the federal Privacy Rule, refer to the detailed statement of this Notice. You can ask for a written copy of the detailed Notice by contacting the Office of the Privacy Officer or by visiting ERS' web site at **ers.texas.gov/about-ers/policies**. If you have any questions or complaints, please contact the ERS Privacy Officer by calling (512) 867-7711 or (877) 275-4377 or by writing to ERS Privacy Officer, The Employees Retirement System of Texas, P.O. Box 13207, Austin, TX 78711-3207.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization. For information on prior authorization, contact your plan administrator.

ADDENDUM – CALCULATING ALLOWABLE AMOUNTS

Allowable Amounts are determined by BCBSTX in accordance with its reimbursement policy guidelines. Reimbursement policy guidelines include, but are not limited to, multiple surgery, Multiple Procedure Payment Reduction (MPPR) packaged services, National Correct Coding Initiative (NCCI) edits, and medically unlikely edits. BCBSTX develops its reimbursement policy guidelines, in BCBSTX' discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

• as indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;

• as reported by generally recognized professionals or publications;

• as used for Medicare; or

• as determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that BCBSTX accepts.

Allowable Amounts are determined using payment methodologies that may include a diagnosis-related group (DRG), fee schedule, package pricing, global pricing, per diem, case-rate, capitation, discount, or other payment methodology.

Allowable Amounts for Contracted Providers

The Allowable Amount for Contracted Providers is determined by the Contracted Provider's agreement with BCBSTX and the BCBSTX reimbursement policy guidelines.

Allowable Amounts for Non-Contracted Providers

- All **Non-Contracted Provider** Allowable Amounts are subject to the following:
    - Where Allowable Amounts for Covered Health Services are based on the BCBSTX average contracted rate for PPO network Hospitals and Providers:
        - they are specific to the BCBSTX-defined PPO network geographic regions;
        - they reflect the average PPO network contracted rate for the applicable region or statewide as indicated below; and
        - they are subject to BCBSTX-defined PPO network reimbursement policy guidelines.
    - Where Allowable Amounts for Covered Health Services are based on Medicare rates;
        - The "Medicare rate" means the rate for the geographic market, defined by zip code, allowed by the Centers for Medicare and Medicaid Services ("CMS") for Medicare. The Medicare rate is derived from CMS information and Medicare regulation, CMS reimbursement policy guidelines, and/or edits (collectively "Medicare Policies") and updated by BCBSTX on a quarterly basis within ninety (90) days following the effective date of CMS implementation of the change.
        - Allowable Amounts determined by BCBSTX using the Medicare rate will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim including, but not limited to, bonus payments, disproportionate share, and graduate medical education payment.

- if a claim includes a Covered Health Service that (a) does not have a rate allowed by Medicare and (b) the service is not otherwise excluded from a payment by Medicare in accordance with Medicare Policies, Allowable Amounts are calculated when received:
    - By a Facility other than a laboratory or diagnostic imaging center: at 50% of billed charges for the covered service line.
    - By Facility-based Providers/Physicians, Professional Providers providing services in a place of treatment other than a Facility, laboratories, and diagnostic imaging centers: at 75% of the regional BCBSTX' average contracted rate for PPO Network Hospitals and Providers.

Important note: When Non-Contracting Providers may not Balance Bill Participants
Participants may not be billed by Non-Contracted Providers for Covered Health Services for amounts beyond the Plan's Deductible, Copayments and Coinsurance, for (a) emergency care, (b) Facility-Based Provider/Physician services in a Network Facility, (c) diagnostic imaging provider services in connection with a service performed by a Network Provider/Physician, or (d) laboratory services in connection with a service performed by a Network Provider/Physician unless specifically provided for below:

• A Participant may be Balance Billed by a Non-Network Facility-based Physician or Provider in a Network Facility for amounts above the Participant's Deductibles, Copayments, and Coinsurance if the Participant signed a written waiver of Balance Billing protection at least 10 days prior to the delivery of the service; and

• A Participant may be Balance Billed by a Non-Contracting diagnostic imaging Provider or laboratory in connection with a service performed by a Network Provider/Physician if the Participant signed a written waiver of Balance Billing protection at least 10 days prior to the delivery of the service.

- Allowable Amounts for **Emergency Services** are based on the following rate, for the same or similar service, when received**:**
    - By a Facility that is not a Freestanding Emergency Room: at 100% of BCBSTX' average statewide contracted rate for PPO network Hospitals and Providers.
    - By Facility-based Providers/Physicians in a Facility (regardless of the Facility's contracted status): at 110% of the Medicare rate.
    - By a Freestanding Emergency Room: at 75% of the average statewide contracted rate for PPO Network Hospitals, Freestanding Emergency Departments and Freestanding Emergency Rooms.
    - By Air Ambulance: the Medicare rate equivalent to 75% of the average statewide contracted rate for PPO Network Air Ambulance providers.
    - By Ground Ambulance: at 325% of the Medicare rate unless the Ground Ambulance service was provided by a recognized Political Subdivision (PSD) and the PSD published the service on the Texas Department of Insurance portal. When published, the allowable amount will be the amount referenced in that portal.
- Allowable Amounts for **non-Emergency Services** are based on the following rate, for the same or similar service, when received:
    - By Facilities not listed in another category below: at 85% of the Medicare rate.

- By Facility-based Providers/Physicians not listed in another category below, in a Facility (regardless of the Facility's contracted status): at 110% of the Medicare rate.
- By a Freestanding Emergency Room: at 75% of the average statewide contracted rate for PPO network Hospitals, Freestanding Emergency Departments and Freestanding Emergency Rooms.
- By Professional Providers not listed in another category below, in a place of treatment other than a Facility: at 85% of the Medicare rate.
- By professional Mental Health Providers not listed in another category below: at 85% of the Medicare rate.
- By a freestanding dialysis center, home health Provider or Skilled Nursing Facility: at 75% of BCBSTX' average statewide PPO Network Provider contracted rates.

ADDENDUM – YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS UNDER THE NO SURPRISES ACT AND TEXAS LAW

Surprise Billing under Federal Law

You are protected from Surprise Billing (also known as Balance Billing) when you receive emergency Services at a Non-Network Facility, get treated by a Non-Network Provider as part of a visit at a Network Facility, or receive Covered Health Services by a Non-Network air ambulance Provider. If you receive these types of care, as discussed below, your cost-share will be calculated as if you received services from a Network Provider and will apply to any Out-of-Pocket Maximums.

What is "Balance Billing" (sometimes called "Surprise Billing")?

- When you see a Physician, Provider, or Other Provider, you may owe certain out-of-pocket costs, such as a Copays, Coinsurance, and/or a Deductible. You may also have additional costs or, for certain services, have to pay the entire bill if you see a Provider or visit a Facility that isn't in your Network.
- "Non-Network or Non-Contracted Provider" describes Providers and Facilities that haven't signed a contract with your health Plan. Non-Network Providers may be permitted to bill you for the difference between what your Plan agreed to pay, and the full amount charged for a service. This is called "Balance Billing." This amount is likely more than the amount you will pay when you see a Provider in your Network and does not count toward your annual Out-of-Pocket Coinsurance Maximum.
- "Surprise Billing" is an unexpected Balance Billing. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at a Network facility but are unexpectedly treated by a Non-Network Provider.

You are protected from Balance Billing for:

- Emergency Services – if you have an Emergency Condition and get Emergency Services from a Non-Network Provider or Facility, the most the Provider or Facility may bill you is your Plan's Network cost-sharing amount (such as Copays and Coinsurance). You can't be Balance Billed for these Emergency Services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be Balance Billed for these Post-Stabilization Services.
- Certain services at a Network Facility or ambulatory surgical center when Providers are Non-Network - In these cases, the most those Providers may bill you is your Plan's Network cost-sharing amount (such as Copays and Coinsurance). This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or internist services. These Providers can't Balance Bill you and may not ask you to give up your protections not to be Balance Billed.
- Covered Health Services by a Non-Network air ambulance Provider. These Providers can't Balance Bill you and may not ask you to give up your protections not to be Balance Billed.

If you get other covered services at Network Facilities, Non-Network Providers can't Balance Bill you, unless you give written consent and give up your protections. You are responsible for payment of the Non-Network Provider's billed charges if, in advance of receiving the services, you signed a written notice that informed you of:

- The Provider's Non-Network status;
- In the case of services received from a Non-Network Provider at a Network Facility, a list of Network Providers at the facility who could offer the same services;
- Information about whether prior authorization or other care management limitations may be required in advance of services; and
- A good faith estimate of the Provider's charges.

Your provider cannot ask you to be responsible for paying billed charges for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other specialists as may be defined by applicable law.

Important Note: You're never required to give up your protections from Balance Billing. You also aren't required to get care in your Network. You can choose a Non-Network Provider or Facility.

If you believe you've been wrongly billed, you may contact:

The No Surprises Helpdesk by calling (800) 985-3059.

Visit **cms.gov/nosurprises/consumer-protections** for more information about your rights under federal law.Visit **healthselectoftexas.com** for more information.

Surprise Billing under Texas Law

You should not be billed for any amounts above your Participant responsibility for Deductibles, Copayments and Coinsurance in the following instances:

- Emergency Services or supplies, including treatment or transportation from ground ambulance service, you receive from a Non-Network Provider;
- Certain services from Non-Network Emergency Medical Services Providers;
- services from a Non-Network Provider that you receive in a Network Facility, unless you agreed in advance to receive the out-of-network services; or
- lab or diagnostic imaging services you receive from a Non-Network lab or diagnostic imaging service that were ordered by a Network Provider unless you agreed in advance to receive the out-of-network services.

If you receive a bill for amounts above your member responsibility in the scenarios listed above without providing your written consent in advance, please contact a BCBSTX Personal Health

Assistant toll-free at (800) 252-8039 (TTY: 711).

If you visit a health care Provider outside of your Plan's Network, they may ask you to sign a form that would allow them to Balance Bill you before they provide any care. **It is very important that you read any paperwork that a Physician asks you to sign. They cannot ask you to sign this form if you received Emergency Services.**

When Balance Billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the Copays, Coinsurance, and Deductibles that you would pay if the Provider or Facility was in your Network). Your health Plan will pay Non-Network Providers and Facilities directly.
- Your health Plan generally must:
    - Cover Emergency Services without requiring you to get approval for services in advance (prior authorization).
    - Cover Emergency Services by Non-Network Providers.

- Base what you owe the Provider or Facility (cost-sharing) on what it would pay Network Provider or Facility and show that amount in your Explanation of Benefits (EOB).
- Count any amount you pay for Emergency Services or Non-Network services toward your Deductible and Out-of-Pocket Maximum.

ADDENDUM – CONTINUITY OF CARE

Your Plan will notify you when your Provider leaves the Network. When one of the following circumstances are met Participants may be able to continue receiving care from their Provider at the Network level of Benefits:

- Participant is undergoing a course of treatment for a serious and complex condition;
- Participant is undergoing institutional or Inpatient care;
- Participant is scheduled to undergo non-elective, including post-operative care;
- Participant is pregnant or undergoing a course of treatment for the Pregnancy;
- Participant has a terminal illness;

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized care over a prolonged period of time.

If your provider has left the Network, and you believe you may qualify as a Continuing Care Patient, fill out a *Continuity of Care Request Form* found at **healthselectoftexas.com**.

A BCBSTX Personal Health Assistant will notify you within 5 business days from receipt of your form to review your request. It is important you provide a daytime phone number on your request. If you do not receive a call within 5 business days, you may contact BCBSTX at (800) 252-8039 (TTY: 711) to check status of your request. In some cases, it may be necessary for BCBSTX to reach out to your Provider/Facility for additional information. Be sure to complete the medical records release authorization on the form.

Formal written notice on determination of your request will be mailed to you when review is completed.

Continuity of Care described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies you of the Provider's termination, or any longer period provided by law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of care may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Master Benefit Plan Document (MBPD).

Important Note: When you receive care as a Continuing Care Patient, your Provider or Facility must accept the Plan's Network Allowable Amount. You should not be Balance Billed for any amounts above your Participant responsibility for Deductibles, Copayments and Coinsurance.

Providers must also continue to adhere to all policies, procedures, and quality standards imposed by the Plan for an individual as if the termination hadn't occurred, including filing claims to BCBSTX.

ADDENDUM - LIST OF COVERED PREVENTIVE CARE SERVICES

Preventive services listed below may change as USPSTF, CDC, and HRSA guidelines are modified and implemented by the Plan as required by applicable law or regulation. Coverage is based on age, risk factors, dosage, and frequency.

Under the Affordable Care Act, certain Outpatient preventive health services are paid at 100% (i.e., at no cost to the Participant), when services are provided by a Network Provider, conditioned upon Physician billing and diagnosis. In some cases, you may be responsible for payment on certain related services that are not guaranteed payment at 100% by the Affordable Care Act.

For details on covered preventive services, visit the BCBSTX Preventive Care website at **healthselectoftexas.com**.

For details on certain preventive services covered by the HealthSelect of Texas Prescription Drug Program (PDP), go to **HealthSelectRx.com** for more information.

<table>
<tr><th colspan="3">List of Covered Preventive Care Services</th></tr>
<tr><th colspan="3">Adults</th></tr>
<tr><th colspan="3">Health Screenings</th></tr>
<tr>
<td>Health Screenings- Adults
Anxiety screening
Blood pressure screening
Cholesterol screening
Type 2 diabetes screening
HIV, HPV and STI screenings
Hepatitis B screening
Hepatitis C screening
Obesity screening and counseling
Tuberculosis screening
Syphilis screening
Depression screening
Baseline and monitoring services tied to utilization of HIV Preexposure Prophylaxis (PrEP) medication.1x
Alcohol and drug use assessment
Falls prevention
Tobacco use screening</td>
<td>Women
Osteoporosis screening
Chlamydia infection screening
Gonorrhea and syphilis screening
BRCA Genetic Testing and counseling
Contraceptive methods and counseling
Well-woman visits
Urinary incontinence screening
Men
Abdominal aortic aneurysm one-time screening</td>
<td>Pregnant Women
Anemia screening for iron deficiency
Tobacco cessation counseling
Syphilis screening
Hepatitis B screening
Rh incompatibility blood type testing
Bacteriuria urinary tract infection screening
Breastfeeding consultation, counseling, education by clinicians, and peer support; and breastfeeding equipment and supplies
Gestational diabetes screening
HIV screening
Depression screening
Preeclampsia screening
Healthy weight gain counseling</td>
</tr>
</table>

List of Covered Preventive Care Services (Cont'd)		
Adults		
Health Screening Cont.	**Health Counseling**	**Immunizations**
<u>Cancer Screenings- Adults</u> • Breast cancer screening mammography (including digital breast tomosynthesis /3-D mammography) • Cervical cancer pap test for women* • Colorectal cancer screenings including Cologuard (at home screening test), fecal occult blood testing, sigmoidoscopy, colonoscopy, (including specialist consultation prior to screening, anesthesia, polyp removal during screening and pathology). If the results of the initial colonoscopy, test or procedure are abnormal, a follow-up colonoscopy is covered same as initial screening* • Lung cancer screening	<u>Health Counseling- Adults</u> Physicians are encouraged to counsel patients about these health issues and refer them to appropriate resources as needed: • Healthy diet • Weight loss • Tobacco use • Alcohol misuse • Prevention of STIs • Use of aspirin to prevent cardiovascular disease • Intimate partner violence screening • Skin cancer behavioral health counseling for young adults, adolescents, children and parents of young children. • Breast cancer chemoprevention	<u>Immunizations- Adults</u> • Haemophilus influenza type B • Hepatitis A and B • Herpes Zoster (Shingles) • Human Papillomavirus (HPV) • Influenza (Flu) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal (pneumonia) • Tetanus, Diphtheria, Pertussis • Varicella (chicken pox) • COVID-19 (covered at 100% when provided by a Network or Non-Network Provider) • Respiratory Syncytial Virus (RSV) • Monkeypox Virus (Mpox)

List of Covered Preventive Care Services (Cont'd)		
Children		
Health Screenings	**Health Screening/Counseling**	**Immunizations**
<u>Health Screenings- Newborns</u> • Screening for hearing loss, hypothyroidism, sickle cell disease, and phenylketonuria (PKU) • Gonorrhea preventive medication for eyes • Bilirubin concentrated screening • Blood screening • Critical congenital heart defect screening • Vision screening	<u>Health Screenings- Children</u> • Medical history for all children throughout development • Height, weight, and Body Mass Index (BMI) measurements • Developmental screening • Autism screening* • Behavioral assessment • Visual acuity screening • Oral health risk assessment • Dental caries prevention • Hematocrit or hemoglobin screening • Lead screening • Dyslipidemia screening • Tuberculin testing • Depression screening • Alcohol and drug use assessment • Cervical dysplasia screening • HIV screening • Blood Pressure screening • Hepatitis B screening for adolescents at high risk, • Anemia Screening <u>Health Counseling- Children</u> • Counseling and screening to prevent sexually transmitted infections (STIs) • Tobacco use interventions • Obesity screening and weight management counseling • Skin cancer counseling	<u>Immunizations- Children</u> • Diphtheria, Tetanus, Pertussis • Haemophilus influenza type B • Hepatitis A and B • Human Papillomavirus (HPV) • Influenza (Flu) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal (pneumonia) • Inactivated Poliovirus • Rotavirus • Varicella (chicken pox) • COVID-19 (covered at 100% when provided by a Network or Non-Network Provider) • Respiratory Syncytial Virus (RSV)

ADDENDUM - RESOURCES TO HELP YOU STAY HEALTHY

Holistic Health Management Program

BCBSTX offers a holistic model to health that goes beyond a core set of specific diagnoses. The approach addresses all of the conditions you may struggle with, including diabetes, coronary artery disease (CAD), cardiovascular cluster (angina, peripheral artery disease and atherosclerosis), congestive heart failure (CHF), asthma, chronic obstructive pulmonary disease (COPD), cancer, chronic kidney disease, musculoskeletal conditions such as low back pain, and complex, catastrophic conditions.

Social determinants of health have a significant impact on health outcomes, which is why we have incorporated them into every step of our approach. Your health status is affected by your access to services, the availability of community resources and healthy food choices, caregiver support, and your financial status.

The BCBSTX holistic health management program provides you access to a clinician who:

- facilitates your holistic health needs, regardless of your chronic condition. You will be able to work with a single, dedicated nurse for the duration of your enrollment in the program or your benefit coverage.
- focuses his or her efforts on prevention and education.
- coordinates your health needs through multiple levels of care until you achieve your optimal health.
- identifies clinical interventions and helps coordinate your care with community resources to help eliminate duplicative services and reduce avoidable Inpatient Hospital stays, readmissions and emergency room visits.
- helps you find high quality, cost-efficient Providers to reduce your out-of-pocket expenses.
- works with your Physicians to coordinate your appointments, if appropriate.

Whether you have an upcoming surgery and have questions, recently had a surgery and need follow up support, or if you are managing a condition or are recently diagnosed, a BCBSTX clinician can support you.

If you have questions about this program or wish to enroll, contact BCBSTX at (800) 252-8039 (TTY: 711) and ask to speak with a clinician.

24/7 Nurseline Support and Services: The Right Care at the Right Time

The 24/7 Nurseline is available in English and Spanish to all HealthSelect Participants. The Nurseline can help you decide if you should see your primary care physician, go to an Urgent Care Center or an emergency room, or find other care as necessary.

You can speak with a nurse 24 hours a day, 7 days a week at (800) 581-0368.

Web and Mobile Wellness Programs and Blue Points

The Well onTarget web portal provides a wealth of resources to support your quest for learning and encourage you using a wide range of interactive and educational features.

Key features of the Well onTarget web portal include:

- Self-directed wellness programs designed to support and motivate you to take charge of your health.

- A health assessment with a customized report.
- Online courses on various health and wellness topics; each course includes 6 on-demand lessons that you can complete at your own pace.
- Online health tools and activity trackers; you can also sync your fitness device.
- Set reminders to help you take action or complete an activity.
- Integration with wellness coaching.

You earn points by completing activities in the Well onTarget portal. You can redeem your points by visiting the online shopping mall available through Blue Access for Members.

To access the Well onTarget portal, log in to your Blue Access for Members account at **healthselectoftexas.com**.

You can take your wellness resources on the go with the Well onTarget Always On mobile app, which is available from both the Apple Store and Google Play.

Important Notice about Well OnTarget and Blue Points
As of Jan. 1, 2025, HealthSelect of Texas Participants will no longer have access to the Well onTarget portal or the Blue Points wellness incentive program.

HealthSelect of Texas participants now have access to Buena Vida, a well-being program offered through the HealthSelect of Texas medical plan.

Buena Vida – Benefits You!

Buena Vida, brought to you by the HealthSelect of Texas, is a brand-new program that helps you take control of your well-being. Designed for Texans who serve Texans, Buena Vida is here to help you grab your health by the horns and achieve what matters most to you.

Your health, your goals, your way

Buena Vida is more than a wellness program. It's a judgment-free community committed to helping you live your best life. Whether you want to reach a fitness goal, improve your mental health or work toward financial wellness, Buena Vida is here to support every part of your well-being.

Build community and enjoy rewards

Buena Vida makes improving your well-being simple. We offer easy-to-use tools that allow you to manage it from one convenient place.

On the Buena Vida online portal, you can:

- learn about your overall health
- track progress toward personal goals,
- join statewide fitness challenges,
- connect with your co-workers and
- earn rewards when you complete healthy activities.

To access the Buena Vida Well-Being program, administered by WebMD, visit **webmdhealth.com/buenavida.**

Well onTarget Fitness Program

The Well onTarget Fitness Program is a flexible membership program that gives you unlimited access to a nationwide network of more than 10,000 fitness centers.

Other program perks include:

- No long-term contract required: membership is month-to-month. After you pay a one-time enrollment fee per Participant. Monthly fee vary dependent on which Well onTarget Fitness Program level you enroll in.
- Convenient payment: once you sign up, your monthly fees are paid via automatic credit card or bank account withdrawal.
- Health and wellness discounts: save money using the nationwide complementary and alternative medicine network of 40,000 health and well-being Providers such as massage therapists, personal trainers and nutrition counselors.
- Web resources: locate participating gyms and track your visits online.

It's easy to join the Well onTarget Fitness Program. To join or get more information, call (888) 762-BLUE (2583) Monday-Friday from 7 a.m.-7 p.m. CT or visit the HealthSelect website at **healthselectoftexas.com**.

The Plan reserves the right to discontinue or change this program at any time without notice.

VirtualCheckup® by Catapult Health

The VirtualCheckup by Catapult Health gives HealthSelect℠ medical Plan Participants aged 18 and older living in the U.S. the opportunity to receive a virtual preventive checkup with a nurse practitioner at no cost.

A VirtualCheckup does not replace an annual wellness exam with a PCP. Catapult Health checkups focus on preventive measures, whereas an annual wellness exam from a PCP may include more comprehensive tests and services that can be performed in a doctor's office setting. Catapult Health can share a Participant's preventive checkup results with their PCP if they choose to provide them with the PCP's name and fax number. This will help ensure the Participant's PCP does not request duplicate tests.

A VirtualCheckup includes:

- lab-accurate results, blood pressure, height, weight, Body Mass Index and abdominal circumference,
- a detailed Personal Health Report available on a secure portal following a confidential video consultation on a smart phone, tablet, laptop, or desktop computer and
- a review of current medications, health conditions and the Personal Health Report with a certified nurse practitioner.

To sign up for a VirtualCheckup, eligible Participants should register to receive a home collection kit at **virtualcheckup.com/healthselect**.

Important notice for women:
Catapult Health recommends all pregnant women visit their regular OB/GYN for all prenatal care, including blood tests. Participation in the VirtualCheckup is not recommended for pregnant women. This VirtualCheckup is also not recommended for women who've had a double mastectomy with bilateral lymph node removal. If either of these apply, the Participant should continue to seek medical care with their PCP and/or other provider(s).

Hello Heart

The Hello Heart program focuses on your cardiovascular health, aiming to prevent or decrease the progression of heart disease and other related health conditions.

The program includes a free Hello Heart blood pressure monitor that pairs with your smartphone. Through this technology, you can:

- understand and manage your blood pressure;
- get help with improving your cholesterol levels and remembering to take your blood pressure medication;
- detect irregular heartbeat; and
- bring awareness to serious heart issues.

HealthSelect℠ medical Plan Participants aged 18 and older living in the U.S. are eligible to enroll. Participants must also have one or more of the following health conditions to be eligible to participate in the program during the initial self-evaluation:

- blood pressure readings of 130/80 mmHg or higher;
- currently taking medication for treatment of cardiovascular disease, including but not limited to blood pressure and/or cholesterol medication;
- increased risk for cardiovascular disease (CVD) such as family history; or
- a woman aged 52 or older who is going through or has gone through menopause.

To enroll, go to **helloheart.com/go-ers** from your smartphone, tablet or computer.

Hinge Health

Hinge Health is a digital, physical therapist (PT)-led musculoskeletal (MSK) care program. The Hinge Health program is offered at no cost to HealthSelect℠ medical Plan Participants aged 18 and older living in the U.S. and includes access to the Hinge Health mobile app and a care team including a board-certified health coach and physical therapist.

This digital program is focused on exercise therapy designed to address a wide range of MSK health conditions. It can be done anywhere, at any time. The program includes:

- personalized exercise therapy to improve strength and mobility in short, 15-minute sessions,
- one-on-one health coaching to provide motivation and support via text, email or phone and
- interactive education to teach you how to manage your condition, treatment options and more.

HealthSelect of Texas medical plan Participants, including those enrolled in Consumer Directed HealthSelect, who are age 18 and older, living in the United States are eligible to participate in the program.

To enroll, go to **hinge.health/healthselect** from your smartphone, tablet or computer.

Learn to Live

Learn to Live gives HealthSelect℠ medical Plan Participants aged 13 and older living in the U.S. access to an online, on-demand, self-paced mental health service grounded in cognitive behavioral therapy (CBT). This style of therapy focuses on thoughts and actions and how changing those can positively impact your state of mind. Learn to Live provides online, coach-supported programs to help Participants overcome depression, insomnia, panic, stress, anxiety and worry, social anxiety and substance use. Participants can also work with a Learn to Live Coach via their preferred communication method after completing an initial assessment.

All Learn to Live programs are accessed online and use videos and interactive features to engage a Participant. An internet connection, smartphone, tablet or computer and a quiet place or headphones are needed to use Learn to Live programs and services. It works on any device – Android, iOS, PC, MAC, laptop or tablet.

To enroll, go to **learntolive.com/welcome/ERS** from your smartphone, tablet or computer.

Doctor on Demand and MDLIVE

Medical Virtual Visits

You have access to a licensed board-certified doctor 24 hours a day, 7 days a week, including weekends and holidays with Virtual Visits through Doctor on Demand and MDLIVE. Medical Virtual Visits are typically one-time consultations with a provider about a specific medical condition, including but not limited to:

- Allergies
- Bladder/Urinary tract infection
- Bronchitis
- Cold and flu
- Headache
- Nausea
- Pink eye
- Sore throat
- Rash

Connect with a medical doctor via online video or by telephone anywhere a connection is available.

Mental Health Virtual Visits

Mental Health Virtual Visits are similar to an outpatient visit at a provider's office, but the visit is conducted online. You must make appointments in advance – appointments are typically available within five to seven days on average but could take up to two weeks. Providers include licensed mental health professionals such as therapists, social workers, psychologists and psychiatrists who can address issues such as:

- Anxiety
- Depression
- Relationship issues
- Trauma and loss
- Insomnia
- Addiction
- Stress
- Anger Management

For mental health Virtual Visits, connect via video conference. Telephone only is not available for mental health Virtual Visits.

You have a choice between two providers:

Doctor On Demand
doctorondemand.com
(800) 997-6196 (TTY: 711)

MDLIVE
mdlive.com/healthselect
(800) 770-4622 (TTY: 711)

See Section 5, *Schedule of Benefits and Coverage* for benefit details.

HealthSelectShoppERS℠

HealthSelectShoppERS is a program where eligible HealthSelect Participants can save money and earn incentives when shopping for and choosing lower cost network Facilities for certain medical services.

HealthSelectShoppERS is available to all benefits-eligible, active employees enrolled in HealthSelect of Texas, HealthSelect Out-of-State or Consumer Directed HealthSelect. Medicare primary Participants, COBRA Members, HealthSelect Secondary Participants and Retirees are not eligible for the HealthSelectShoppERS rewards program. Return-to-work Retirees who have elected active coverage and who are enrolled in HealthSelect of Texas are eligible to participate. If a return-to-work Retiree chooses retiree benefits, he/she is not eligible for HealthSelectShoppERS.

To earn a reward, Participants in the HealthSelectShoppERS program must have active coverage in HealthSelect of Texas, HealthSelect Out-of-State, or Consumer Directed HealthSelect on the date they shop for a rewards-eligible service, as well as the date the medical claim for the service is processed by BCBSTX. Additionally, Participants must be eligible for a TexFlex℠ health care Flexible Spending Account (FSA) on the date the incentive is received and processed by ERS in order to earn the incentive. To receive the reward, the rewards-eligible service must be completed within thirteen months of shopping.

The program seamlessly integrates with BCBSTX' Provider Finder tool found within Blue Access for Members (BAM). Eligible HealthSelect Participants can shop through the Provider Finder for certain elective, non-emergency medical services ordered by the Provider that are eligible for an incentive. Shopping can also be conducted by calling a BCBSTX Personal Health Assistant.

When Participants shop for services, results are sorted and show the locations with the highest eligible incentive and lowest cost. Generally, the first, second, and third lowest cost options have corresponding incentives that can be earned.

The incentive amount is driven by the price variance between Facilities and not individual Providers performing the procedure. Services eligible for an incentive include, but are not limited to: MRIs, CT Scans, mammograms, and knee, shoulder, and hip surgery. The full list of eligible services is available in Provider Finder. Log into Blue Access for Members at **healthselectoftexas.com**, click "My Health" and from the dropdown choose "Find Care", then click "Find a Doctor or Hospital" and then on "HealthSelectShoppERS." All eligible services will be listed under the search bar. Incentive amounts and eligible services are subject to change.

There may be times where your Provider refers you to a Facility or location to complete your medical service or procedure that is not eligible for a reward. This decision on where to get care is always between you and your Physician. However, you must use a Facility that is eligible for the program to receive a reward. If your Provider performing the medical service or procedure refers you to a Facility that is not eligible for a reward under the program, a BCBSTX Personal Health Assistant may be able to help coordinate the service with your Provider at a different Facility or location (depending on your Provider's privileges). In some instances, your Provider may be unable to change your procedure or service to a rewards' eligible location. For assistance, call a BCBSTX Personal Health Assistant at (800)252-8039 (TTY: 711). Remember, you can keep your out-of-pocket costs lower by choosing in-Network Providers.

After shopping for a Cost-Effective service using the Provider Finder or by calling a Personal Health Assistant, a Participant then completes their service with the Provider that is associated with their shopping history on file with BCBSTX.

To view your shopping history, log into Blue Access for Members at **healthselectoftexas.com** and click the "Doctors and Hospitals" tab and then on "Find a Doctor or Hospital" and then on your name on the top right of the screen. Select "Your Profile" from the dropdown menu to see your shopping history.

BCBSTX will process the medical claim once received from the Facility and will tie the medical claim to the incentive earned.

The incentive will be deposited into an eligible Subscriber's TexFlex health FSA usually within 30-45 days of the date the medical claim is processed by BCBSTX. If you are not already enrolled in an FSA, ERS will set up an account for you. Rewards earned in December will be processed in January of the following year. If it has been more than 45 days since you completed a rewards-eligible service that you shopped for and your reward is not available in your TexFlex FSA, please call a BCBSTX Personal Health Assistant for assistance.

Incentives are made as employer contributions as a credit into the Participant's FSA. A maximum reward of $500 per member (including Dependents) can be earned each Plan Year and is subject to current FSA carry-over and forfeiture rules.

Employer contributions are made in addition to Employee's annual contribution amount. A Participant can elect the maximum contribution amount and still be eligible to receive up to $500 in incentives during the Plan Year.

The employer contribution is not taxable income but will be reflected on the Employee's Form W-2 following the conclusion of the Calendar Year.

Each family (meaning a Subscriber and their covered Dependents) can earn up to $500 in HealthSelectShoppERS incentives each Plan Year. The incentives earned can be used in paying for a qualified FSA expense as defined by the Internal Revenue Service. For more information on the TexFlex program, visit **TexFlex (inspirafinancial.com)** or contact TexFlex customer care toll-free at (866) 353-9839 (TTY: 711). Representatives are available from 7 a.m. to 7 p.m. CT, Monday-Friday, and 9a.m. to 2 p.m. CT, Saturday.

If you have questions about this program, contact a BCBSTX Personal Health Assistant at (800) 252-8039 (TTY: 711).

Remember, all decisions on where to receive care are between you and your Provider. The Plan reserves the right to discontinue or change this program at any time without notice.

ProgenyHealth for Neonatal Care

ProgenyHealth's services are provided at no additional cost to HealthSelect℠ medical Plan Participants living in the U.S. following a neonatal intensive care unit (NICU) admission. Soon after an eligible infant is admitted to the NICU, a ProgenyHealth case manager will reach out to the infant's primary caregiver to introduce the program and explain the benefits of the ProgenyHealth program.

ProgenyHealth provides telephonic neonatal care management services for newborns admitted to the neonatal intensive care unit (NICU) or special care nursery (SCN). The program promotes evidence-based best practices and is tailored to meet the health care needs of each infant. ProgenyHealth works closely with the doctors, nurses and other staff in the hospitals and provider offices to perform utilization review and medical management services. The program supports families from their infant's initial NICU admission up to the through their first year of life to make sure they are educated and empowered in their infant's care.

ProgenyHealth's Case Management department includes nurse case managers, social workers, and case management associates who deliver comprehensive services over the phone. ProgenyHealth's team will reach out to families during the Inpatient Stay to talk about case management needs and also work with Hospital discharge planners and Hospital social workers to safely transition babies from the Hospital to their home. ProgenyHealth's case managers will continue to provide ongoing education to the family and help with care coordination after leaving the Hospital.

Wondr and Real Appeal

The following programs are available to eligible Participants at no additional cost:

Wondr

The Wondr program can provide lasting weight loss, and it doesn't include starving, counting calories or eating diet food.

It's 10-week online program that helps you eat right to reduce your risk of getting a serious disease, like diabetes or heart disease, and improves your chances of living a happier and healthier life. The easy-to-follow program is led by subject matter experts who will provide ongoing support at the end of the program to help you maintain your weight loss success.

The program features informative videos and learning tools to teach you how to lose weight and improve your overall health. You can connect on your computer or mobile device – apps for iPhone and Android devices are available – and access videos, programs and recipes. A starter kit is mailed directly to your home.

Wondr is available to HealthSelect℠ medical Plan Participants aged 18 and older (excluding Medicare primary Participants) who have a BMI of 23 or higher.

To enroll, go to **wondrhealth.com/healthselect** from your smartphone, tablet or computer.

Real Appeal

Real Appeal is an online weight loss program that provides a fresh approach to help you lose weight. The program helps you develop healthy habits that can lead to long-lasting results. Whether you want to drop a few pounds or make a more significant change, Real Appeal may help you shed pounds and lead a healthier life.

Real Appeal provides you with online coaching support sessions for 52 weeks to teach you healthy habits. You'll also receive a Success Kit and access to online resources to help you apply what you've learned.

Real Appeal is available to HealthSelect medical Plan Participants aged 18 and older. (excluding Medicare primary Participants) who have a BMI of 23 or higher.

To enroll, go to **healthselect.realappeal.com** from your smartphone, tablet or computer.

Please Note: Real Appeal is not available outside the United States, except for Puerto Rico.

Important note about dual enrollment in Wondr and Real Appeal
HealthSelect Participants are not able to receive services and benefits from Wondr and Real Appeal at the same time.

If you receive services from both Wondr and Real Appeal within a 7-calendar day period, those services will be denied because the Benefit maximum will have been reached.